C-500

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 11501 **CERTIFICATE OF DEATH** Registered No. 67 11501

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HERMAN A. COHEN (HYMAN)

2. DATE AND HOUR OF DEATH: 11/24/67 5 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-20
D. STREET ADDRESS (If rural, give location): 2900 GLEN AVENUE, APT. B

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE +	MARRIED	3-10-94	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
UNITED BROADCASTING CO.	CONSULTANT	RUSSIA	U.S.A.

13. FATHER'S NAME: CHARLES COHEN

14. MOTHER'S MAIDEN NAME: SARAH LEOH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MRS. REBA COHEN
ADDRESS: 2900 GLEN AVENUE, APT. B

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ARTERIOSCLEROTIC HEART DISEASE — 10 YRS.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from FALL 1957 to NOV. 24, 1967, that (I) (~~we~~) last saw the deceased alive on NOV. 24, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Marvin Goldstein M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 11/24/67

23C. PHYSICIAN'S NAME (Type): MARVIN GOLDSTEIN M.D.

23D. ADDRESS: 6001 PARK HEIGHTS AVE. BALTO. MD

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	11-26-67	CHIZUK AMUNO	~~XXXX~~ BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: OCT 1 1967

25B. NAME OF REGISTRAR: D. A. E. Fa[illegible] M.D.

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC.
ADDRESS: 6010 REISTERSTOWN RD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B-320

M.E. CASE NO. 67 11502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11502

1. NAME OF DECEASED (Type or Print): Herman E. Baddock

2. DATE AND HOUR OF DEATH: 11/26/67 | 9:07 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-20

D. STREET ADDRESS (If rural, give location): 7118 Boxford Road

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 8-3-00

9. AGE (In years last birthday): 67

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): A'CCT. BOOKKEEPER

10B. KIND OF BUSINESS OR INDUSTRY: COMPANY

11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH BADDOCK

14. MOTHER'S MAIDEN NAME: ~~EXXXX~~ BESSIE CANNAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MRS. JEAN BADDOCK, 7118 BOXFORD ROAD #21215

ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1

(A) DUE TO: Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days

(B) DUE TO: ASCVD — 5 years

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: None

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 11/22/1967 to 11/26/1967, that I (we) last saw the deceased alive on 11/26 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) did (did not) view the body after death.

23A. SIGNATURE: Neil R. Williams, M.D. — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 11/26/67

23C. PHYSICIAN'S NAME (Type): DR. NEIL R. WILLIAMS M.D.

23D. ADDRESS: 6062 E Pratt St, Baltimore, Md

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 11-28-67

24C. NAME of CEMETERY or CREMATORY: SHAAREI ZION

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967

25B. NAME OF REGISTRAR: D. B. F. Fahrney

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD

ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

BIRTH NO. 2-345 67 11503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11503

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANNA ZEITLIN

2. DATE AND HOUR OF DEATH: NOVEMBER 26, 1967 — 4 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2302 CREST ROAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 2795

D. STREET ADDRESS (If rural, give location): 2302 CREST ROAD

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	WIDOWED	12-18-1876	90		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	AT HOME	RUSSIA	U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		220-48-7532	MRS. ROSE POSEN	2302 CREST ROAD #21209

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Acute Cardiac Dilatation	1 day
DUE TO (B)	ASHD	2 years
DUE TO (C)	Recurrent C.H.F.	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/13 1966 to 11/26 1967, that (I) (we) last saw the deceased alive on 11/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: I. Zinberg M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 11/27/67

23C. PHYSICIAN'S NAME (Type): ISRAEL ZINBERG M.D.

23D. ADDRESS: 4000 W. NORTHERN PKWY.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	11-27-67	NEW HAR SINAI	BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 1 1967	Robert E. Farley M.D.	SOL LEVINSON & BROS. INC.,	6010 REISTERSTOWN RD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. G-432

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

67 11504

Registered No. 67 11504

1. NAME OF DECEASED (Type or Print): Joseph Goldstein

2. DATE AND HOUR OF DEATH: Nov. 26, 1967 1:15 A.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 ~~Sinai~~ Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: U.S.A.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 2707

D. STREET ADDRESS (If rural, give location): 3207 Ingleside Ave

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 12/25/97

9. AGE (In years last birthday): 69

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MANAGER

10B. KIND OF BUSINESS OR INDUSTRY: SPA BAR

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MRS. LOTTIE GOLDSTEIN, ADDRESS: 3207 INGLESIDE AVE. #15

MEDICAL CERTIFICATION

1B. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial Infarction — 14 days

DUE TO

(B) Cerebral Vascular Accident — 2 days

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 12 19 67 to Nov. 26 19 67, that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard J. Baer M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Nov. 26, 1967

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 11-27-67

24C. NAME of CEMETERY or CREMATORY: BNAI ISRAEL

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967

25B. NAME OF REGISTRAR: Robert E. Fahey

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., ADDRESS: 6010 REISTERSTOWN RD

VS 150-REV. 1/1/65

1 6-432

BIRTH NO. 67 11505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11505

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Goldgeier Henry

2. DATE AND HOUR OF DEATH: 11-27-1967 | 12¹⁰ a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-17

D. STREET ADDRESS (If rural, give location): 3028 W. GARRISON AVENUE

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: MAY 26, 1899

9. AGE (In years last birthday): 68

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GROCERY

10B. KIND OF BUSINESS OR INDUSTRY: WHOLESALE

11. BIRTHPLACE (State or foreign country): NEW YORK

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MAX GOLDGEIER

14. MOTHER'S MAIDEN NAME: BERTHA SCHNETEK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 110-09-5563

17. INFORMANT: MRS. DORA GOLDGEIER

ADDRESS: 3028 W. GARRISON BLVD. #15

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 571.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) (Extensive) Bronchopneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B) Agranulocytosis

DUE TO (C) Enterocolitis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-24 1967 to 11-27 1967, that (I) (we) last saw the deceased alive on 11-27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Myung Sun Yoon M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): MYUNG SUN YOON M.D.

23D. ADDRESS: SINAI HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 11-28-67

24C. NAME of CEMETERY or CREMATORY: WORKMENS CIRCLE

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC.

ADDRESS: 6010 REISTERSTOWN RD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and, the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

F-635

BIRTH NO. 67 11506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11506

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FREEDMAN, IDA

2. DATE AND HOUR OF DEATH: 11-29-1967 | 6-45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LEVINDALE HEBREW HOME GREENSPRING & BELVEDERE AVE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-13
D. STREET ADDRESS (If rural, give location): 2532 LOYOLA SOUTHWAY #15

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: JUNE 15, 1896
9. AGE (In years last birthday): 71 ~~XXXX~~
If Under 1 Yr. Months: Days: Hours: If Under 24 Hrs. Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DOMESTIC
10B. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): LITHUANIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: AARON FREEDMAN
14. MOTHER'S MAIDEN NAME: GISSA ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MR. EARL SWARTZ, ADDRESS: 7419 PRINCE GEORGE RD. #7

MEDICAL CERTIFICATION

18. 163X I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA LEFT LUNG WITH — 7 years

DUE TO PLEURAL EFFUSION

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIOSCLEROTIC CEREBRO AND CARDIOVASCULAR DISEASE — 10 years

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-31-1960 to 11-29-1967, that (I) (we) last saw the deceased alive on 11-28-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: T. K. Raman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 11-29-1967
23C. PHYSICIAN'S NAME (Type): T. K. RAMAN M.D.
23D. ADDRESS: SINAI HOSPITAL, BALTIMORE, MD 21215

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 11-29-67
24C. NAME of CEMETERY or CREMATORY: BETH ISAAC ADATH ISRAEL
24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967
25B. NAME OF REGISTRAR: Robert E. Tankersley
25C. FUNERAL DIRECTOR: Joel Levenson Bros Inc.
ADDRESS: 6010 REISTERSTOWN RD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. N-550 67 11507

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11507

1. NAME OF DECEASED (Type or Print): ANNIE NEWMAN

2. DATE AND HOUR OF DEATH: NOVEMBER 28, 1967 | 9 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3413 LUDGATE ROAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-20
D. STREET ADDRESS (If rural, give location): 3413 LUDGATE ROAD

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW
8. DATE OF BIRTH: 10-10-1880
9. AGE (In years last birthday): 87
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): RUSSIA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: LAIB FREIBERG
14. MOTHER'S MAIDEN NAME: MUTTEL ?
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-32-4347
17. INFORMANT: MR. SOL NEW MAN
ADDRESS: 3413 LUDGATE ROAD #21215

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 170X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) C. V. A. — 1 day
DUE TO
(B) H H J H D — 10 years
DUE TO
(C) Metastatic Carcinoma from Lt. Breast Surgery 1956 — 11 years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 5/24/1956
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Radical Left Breast
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/22/1958 to 11/21 19 D, that (I) (we) last saw the deceased alive on 11/21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: H Zinberg
M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 11/21/67
23C. PHYSICIAN'S NAME (Type): ISRAEL ZINBERG M.D.
23D. ADDRESS: 4000 W. NORTHERN PARKWAY

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 11-29-67
24C. NAME of CEMETERY or CREMATORY: BALTIMORE HEBREW
24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967
25B. NAME OF REGISTRAR: Robert E. Faber M.D.
25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC.
ADDRESS: 6010 REISTERSTOWN RD

VS 150-REV. 1/1/65

1

S-44

67 11508 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 11508 Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SIMON SILVERMAN

2. DATE AND HOUR PRONOUNCED DEAD: November 27, 1967 1:55 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Church Home and Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 308 S. Eden Street

3-02

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	SINGLE	JUNE 19, 1903	64				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SALESMAN	RETAIL	ENGLAND	U.S.A.

13. FATHER'S NAME: JULIUS SILVERMAN

14. MOTHER'S MAIDEN NAME: ROSE R FREEDMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 215-01-2331

17. INFORMANT: MR. JACK SILVERMAN, ADDRESS: 1341 SUDVALE ROAD #21208

MEDICAL CERTIFICATION

1B. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 11/27/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	11-28-67	ANSHE EMUNAH AITZ CHAIM	BALTIMORE, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 1 1967	Robert E. Fairbairn	SOL LEVINSON & BROS. INC.,	6010 REISTERSTOWN RD

VS 151-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-620 67 11509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11509

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ESTHER SURASKY

2. DATE AND HOUR OF DEATH: Nov 28 1967 3:15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: Balto Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 7502 SLADE AVENUE #21208

5. SEX: FEMALE 6. RACE: WHITE 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED 8. DATE OF BIRTH: 9-7-1904 9. AGE (In years last birthday): 63 If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE 10B. KIND OF BUSINESS OR INDUSTRY: AT HOME 11. BIRTHPLACE (State or foreign country): ROMANIA 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LOUIS GREENBERG 14. MOTHER'S MAIDEN NAME: PAULINE ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): NO 16. SOCIAL SECURITY NO.

17. INFORMANT: MR. JACOB SURASKY, 7502 SLADE AVENUE #21208 ADDRESS

MEDICAL CERTIFICATION

18. 420.1 + 200.2

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Acute pulmonary edema — Nov 28 3:00 AM
(B) DUE TO: ASCVD — acute myocardial infarction
(C) Metastatic carcinoma fibromyoma (Primary — unknown)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3:00 AM Nov 28 19 67 to Nov 28 3:15 AM 19 67, that (I) (we) last saw the deceased alive on 3:15 AM Nov 28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A S Glushakow M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: Nov 28, 1967

23C. PHYSICIAN'S NAME (Type): A S Glushakow M.D. 23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL 24B. DATE: 11-29-67 24C. NAME of CEMETERY or CREMATORY: SHAAREI TFILOH 24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967 25B. NAME OF REGISTRAR: Robert E. Jankyna 25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD. ADDRESS

VS 150-REV. 1/1/65

BIRTH NO. 5-000 67 11510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11510

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LAWRENCE SHAW

2. DATE AND HOUR OF DEATH: Nov. 28, 1967 11:15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Public Health Service Hospital
3100 Wyman Pk. Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Mass.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Swampscott V-18
D. STREET ADDRESS (If rural, give location): 43 Worcester Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Married	3/1/21	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Rubber Co	NY	USA

13. FATHER'S NAME: Joseph Shaw

14. MOTHER'S MAIDEN NAME: Ida Goldman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): None (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 072-12-7585

17. INFORMANT: Records- US PHS Hospital, Balto, Md. ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
18. 204.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Overwhelming sepsis	1 day
DUE TO	(B) Pneumonia	1 day
ANTECEDENT CAUSES. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (C) Acute leukemia	2 mos.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct. 5 1967 to Nov. 28 1967, that (I) (we) last saw the deceased alive on Nov. 28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Byron S. Hurwitz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X

23B. DATE SIGNED: 11/28/67

23C. PHYSICIAN'S NAME (Type): Byron Hurwitz, SA Surg (R) M.D.

23D. ADDRESS: US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Removal

24B. DATE: Nov. 28/67

24C. NAME of CEMETERY or CREMATORY: Mt. Lebanon

24D. LOCATION (City, town, or county) (State): West Roxbury, Mass.

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967

25B. NAME OF REGISTRAR: Robert E. Fahey

25C. FUNERAL DIRECTOR: Sol Levinson & Bros Inc

ADDRESS: 600 Rest. Road

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

1
W-452

BIRTH NO.

M.E. CASE NO.

67 11511

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11511

1. NAME OF DECEASED (Type or Print): THELMA WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD: November 26, 1967 10:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital

43

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-01
D. STREET ADDRESS (If rural, give location): 129 N. Hill Street

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH:
9. AGE (In years last birthday): 38
If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): DURHAM N.C
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: PRESTON WILLIAMS
14. MOTHER'S MAIDEN NAME: LOTTIE HARRIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: PRESTON WILLIAMS
ADDRESS: 4017 EDMONDSON AVE

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. E 982 X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Stab Wound of Abdomen

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 533 S. Sharp St. 22-01

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 11/26/67 1:45 P. - 2:30 P. m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Subj. stabbed during argument

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 11/27/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12/1/67
23C. NAME of CEMETERY or CREMATORY: Mt Calvary
23D. LOCATION (City, town, or county) (State): A A Co, Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967
24B. NAME OF REGISTRAR: [illegible]
24C. FUNERAL DIRECTOR: Osgood L Brown & Son
ADDRESS: 68 W Montgomery St

VS 151-REV. 1/1/65

N 879.2

P-6001

BIRTH NO. 67 11512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11512

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PERRY, WILLIAM

2. DATE AND HOUR OF DEATH: 11/30/67 | 6 05 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY OF MD HOSP. BALTIMORE, MARYLAND 21201

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: 1842 W. SARATOGA ST 21223
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 20-01
D. STREET ADDRESS (If rural, give location):

5. SEX: M
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 12/7/10
9. AGE (In years last birthday): 57
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DISABLED
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): SOUTH CAROLINA
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: WILLIAM PERRY
14. MOTHER'S MAIDEN NAME: EUGINIA LYLES

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: CHART.
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Bronchopneumonia	4 days
DUE TO		
(B)	Chronic Pulmonary disease	years.
DUE TO		
(C)		

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
for rheumatic aortitis. Postop aortic valve replacement.

19A. DATE OF OPERATION: 11/22/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: aortic valve disease
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/4 1967 to 11/30 1967, that (I) (we) last saw the deceased alive on 30 Nov 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard S. Leacock M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 11/30/67
23C. PHYSICIAN'S NAME (Type): FERDINAND S. LEACOCK M.D.
23D. ADDRESS: University of Maryland Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/4/67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967
25B. NAME OF REGISTRAR: Robert E. Fielding
25C. FUNERAL DIRECTOR: Marshall A. Hoyer
ADDRESS: 638 N Gilmor St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11513 Registered No. 67 11513

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FRED B. FERGUSON, JR.

2. DATE AND HOUR OF DEATH: 11-29-67 | 7:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: HARFORD Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): JOPPA 62-00

D. STREET ADDRESS (If rural, give location): 1503 MANDYBILLE RD.

5. SEX: M

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 6-18-29

9. AGE (In years last birthday): 38

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): LAURENS Co S.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRED FERGUSON, SR.

14. MOTHER'S MAIDEN NAME: ROSA KENNEDY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: FRED FERGUSON JOPPA MD

ADDRESS:

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

416X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Congestive Heart Failure — 3 wks

DUE TO

(B) Bacterial Endocarditis — 6 mos

DUE TO

(C) Rheumatic Heart Disease — 30 yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-20 1967 to 11-29 1967, that (I) (we) last saw the deceased alive on 11-29 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J V Russo M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 11/29/67

23C. PHYSICIAN'S NAME (Type): J. V. RUSSO M.D.

23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Removal

24B. DATE: 12/1/67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State): Laurens Co. S.C.

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Marshall P Hyson

ADDRESS: 6581 Gilmor St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11514 Registered No. 67 11514

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARY E. JOHNSON

2. DATE AND HOUR OF DEATH: 11/27/67 10:30 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 16-01

D. STREET ADDRESS (If rural, give location): 1121 N Carey Street #17

38

5. SEX: Female 6. RACE: Negro 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widower 8. DATE OF BIRTH: 3-6-99 9. AGE (In years last birthday): 68 If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 10B. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Lancaster VA. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Titus Johnson 14. MOTHER'S MAIDEN NAME: Hattie Diggs VA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-05-6949

17. INFORMANT: Frey Johnson ADDRESS: 1121 CAREY ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 260 X

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 dy

DUE TO

(B) Bilateral Cerebral Infarction — 4 "

DUE TO

(C) Diabetes mellitus — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/20/67 19 67 to 11/27 19 67 that (I) (we) last saw the deceased alive on Nov 27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stephen Hamroff M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 11/27/67

23C. PHYSICIAN'S NAME (Type) M.D. 23D. ADDRESS: 5942 Greenmeadow Parkway 21209

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 11/30/67 24C. NAME of CEMETERY or CREMATORY: Queen Esther Cem. 24D. LOCATION (City, town, or county) (State): Lancaster Co, Virginia

25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR: Kelson Funeral Home ADDRESS: 1348 Calhoun St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-1601

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11515

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11515

1. NAME OF DECEASED (Type or Print): Cornelia G. Hooper

2. DATE AND HOUR OF DEATH: 11-30-67 | 3:40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Lincoln Memorial Nursing Home 27 N. Carey St. Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and name township): Balto. 14-03

D. STREET ADDRESS (If rural, give location): 508 W. Laurens Street

5. SEX: Female

6. RACE: Negroid

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: 5-11-82

9. AGE (In years last birthday): 85

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Rubin Jordon

14. MOTHER'S MAIDEN NAME: Winnie Middleton

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Verninia Rich

ADDRESS: 1614 N. Smallwood St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 443X

(A) Hypertensive arteriosclerotic C.V.D

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Upper respiratory infection — 5 days

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 8, 1965 to November 30, 1967, that (I) (~~we~~) last saw the deceased alive on November 28, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: CR. Campbell, M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 11-30-67

23C. PHYSICIAN'S NAME (Type): C. R. Campbell, M.D.

23D. ADDRESS: 1618 W. North Ave., Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-3-67

24C. NAME of CEMETERY or CREMATORY: Church Cemetery

24D. LOCATION (City, town, or county) (State): Northumberland, Va.

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Kelson Funeral Home

ADDRESS: 1348 Calhoun St.

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-656

BIRTH NO. 67 11516

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11516

1. NAME OF DECEASED (Type or Print): VIOLA CRONER

2. DATE AND HOUR OF DEATH: NOV. 27, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Bella' Mae Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY: 20-04

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto.

D. STREET ADDRESS (If rural, give location): 147 S. Calverton Rd.

5. SEX: Female

6. RACE: Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH: June 14, 1897

9. AGE (In years last birthday): 70

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): n

16. SOCIAL SECURITY NO.:

17. INFORMANT: Thelma Banks ADDRESS: 147 S. Calverton Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Acute Coronary thrombosis — 3 Hours

DUE TO

(B) Arteriosclerosis — ?

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (~~this hospital~~) attended the deceased from 5-29- 1965 to 11-27- 1967, that (I) (~~we~~) last saw the deceased alive on 10-24-1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Eugene H. Owens M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): Eugene H. Owens M.D.

23D. ADDRESS: 1735 E. Federal St Baltimore Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/1/1967

24C. NAME of CEMETERY or CREMATORY: Balto. National Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967

25B. NAME OF REGISTRAR: Robert E. Faber, M.D.

25C. FUNERAL DIRECTOR: Williams Funeral Home

ADDRESS: 3199 N. Schroeder

VS 150-REV. 1/1/65

1

B-624 67 11517

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11517

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MABEL BRASWELL

2. DATE AND HOUR PRONOUNCED DEAD: November 28, 1967 8:41 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1619 Sarah Ann St. (DOA)

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-01
D. STREET ADDRESS (If rural, give location): 1619 Sarah Ann Street

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Sept. 26, 1940
9. AGE (In years last birthday): 27
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Alcorn
14. MOTHER'S MAIDEN NAME: Emma Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Milton Alcorn ADDRESS: 5046 Chalgrove Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

581.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fatty Alteration of Liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 11/28/67

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial
23B. DATE: Dec 2, 1967
23C. NAME OF CEMETERY OR CREMATORY: Mt Auburn Cem.
23D. LOCATION (City, town, or county) (State): Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: Williams Funeral Home
ADDRESS: 3199 W. Lafayette St.

VS 151-REV. 1/1/65

M-635

67 11518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11518

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JEANIE MAY MARTIN — Martin, Jeanie May

2. DATE AND HOUR OF DEATH: 11/30/67 | 9 00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 902 N. Linwood Ave

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 01/02/95
9. AGE (In years last birthday): 71
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N. Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Voe Horne
14. MOTHER'S MAIDEN NAME: Mary Bell

15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217 54 4433
17. INFORMANT: Charles W. Martin Sr. — ADDRESS: 902 N. Linwood Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

1B. 420.1

(A) DUE TO: Acute MI — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

(B) DUE TO: Arteriosclerotic Cardiovascular disease

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/12/1967 to 11/30/1967, that (I) (we) last saw the deceased alive on 11/30/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: H F Holcomb — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 11/30/67
23C. PHYSICIAN'S NAME (Type): HARRY F. HOLCOMB JR. MD.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL, Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-4-1967
24C. NAME of CEMETERY or CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Lilly & Zeiler Inc. — ADDRESS: 1901-07 Eastern Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W3001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11519 Registered No. 67 11519

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ELEANOR M. WHITE

2. DATE AND HOUR OF DEATH: 11-30-67 1:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LITTLE SISTERS OF THE POOR, 1200 VALLEY STREET, BALTIMORE, MARYLAND 21202 — 90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 10-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1200 VALLEY ST.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: 9-10-1904
9. AGE (In years last birthday): 63 — If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: MATTHEW WHITE
14. MOTHER'S MAIDEN NAME: DELIA A. GARVEY
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: LITTLE SISTERS OF THE POOR — ADDRESS: 1200 VALLEY ST. BALTIMORE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 199.2 Coronosis

(A) DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ____ 1966 to Nov. 30 1967, that (I) (we) last saw the deceased alive on Nov. 30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stanley Ankudas M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 11.30.67
23C. PHYSICIAN'S NAME (Type): STANLEY ANKUDAS M.D.
23D. ADDRESS: 1101 MAIDEN CHOICE LANE BALT., MD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/2/67
24C. NAME of CEMETERY or CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967
25B. NAME OF REGISTRAR: Robert E. Talkym
25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co. — ADDRESS: 4905 York Road Baltimore, Md. 21212

VS 150-REV. 1/1/65

1

L-000

BIRTH NO. 67 11520

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11520

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARY Y. LEE

2. DATE AND HOUR PRONOUNCED DEAD: November 26, 1967 | 11:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-09
D. STREET ADDRESS (If rural, give location): 1536 Aisquith Street

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: Apr 24-1891
9. AGE (In years last birthday): 76
If Under 1 Yr. Months | Days | Hours | If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Green
14. MOTHER'S MAIDEN NAME: Margaret Filghman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Shirley Roles
ADDRESS: 1910 N. Aisquith St

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Burns Over 80% Of Body Surface Incidental To Conflagration

E 916.0

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1536 Aisquith Street 9-09

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 11/25/67 4:30 P. m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Burned during conflagration

22. I certify that I held an Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz, M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 11/27/67

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial
23B. DATE: 11-29-67
23C. NAME of CEMETERY or CREMATORY: Balto National Cem.
23D. LOCATION (City, town, or county) (State): Balto. Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967
24B. NAME OF REGISTRAR: Robert E. Fasky M.D.
24C. FUNERAL DIRECTOR: Rayner Sanders
ADDRESS: 217 E. Preston St

VS 151-REV. 1/1/65

N 948.2

SAB-50-36-83 1

B50

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11521

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11521

1. NAME OF DECEASED (Type or Print): BRAUN, MARY

2. DATE AND HOUR OF DEATH: 11-29-1967 1205 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel C
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Edgewater 52-00
D. STREET ADDRESS (If rural, give location): Rt. #3, Box #307 21037

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 5-8-1890
9. AGE (In years last birthday): 77
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Tanner
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 340-01-1266 -D
17. INFORMANT: Records: BCH-4940 Eastern Avenue 21224 — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 331 X

(A) Pneumonia

DUE TO

(B) Arteriosclerosis

DUE TO

(C) CVA

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 10-11 1967 to 11-29 1967, that (I) (we) last saw the deceased alive on 11-28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: P. Desmond M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 11-29-67
23C. PHYSICIAN'S NAME (Type): P. Desmond M.D.
23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 12-4-67
24C. NAME of CEMETERY or CREMATORY: MEMORIAL PK. CEM
24D. LOCATION (City, town, or county) (State): CHICAGO ILL

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967
25B. NAME OF REGISTRAR: Robert E. Fashyna
26C. FUNERAL DIRECTOR: James M. Fields
ADDRESS: 4781 Bonnie Brae Rd. Balto Md. 21208

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. H-620

M.E. CASE NO. 67 11522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11522

1. NAME OF DECEASED (Type or Print): William Harris

2. DATE AND HOUR OF DEATH: Nov 26, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 004430 St. George's Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY: 27-10 C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 4430 St George Ave

5. SEX: Male 6. RACE: Colored 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widower 8. DATE OF BIRTH: April 4 1893 9. AGE (In years lost birthday): 74 If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 10B. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): Md. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown 14. MOTHER'S MAIDEN NAME: Nellie ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT: Mary Gorge ADDRESS: 4430 St George Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease

DUE TO

(B)

DUE TO

(C) Anemia

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/19/65 19 to 11/26/67 19, that (I) (we) last saw the deceased alive on 11/25/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W Garner M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 11/30/67

23C. PHYSICIAN'S NAME (Type): W GARNER M.D. 23D. ADDRESS: 1605 W Lafayette ave

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: Nov 30/67 24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park 24D. LOCATION (City, town, or county) (State): Arbutus Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967 25B. NAME OF REGISTRAR: Robert E. Fasbey M.D. 25C. FUNERAL DIRECTOR: Milton E. Elderson ADDRESS: 1129 N. Carrollton St

VS 150-REV. 1/1/65

1

R-600 67 11523

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11523

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALEXANDER RORIE, JR.

2. DATE AND HOUR PRONOUNCED DEAD: November 28, 1967 5:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-01

D. STREET ADDRESS (If rural, give location): 1211 E. Chase Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Married	Aug 30, 1930	37				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed		Md.	

13. FATHER'S NAME: Elias Rorie

14. MOTHER'S MAIDEN NAME: Nezzie Little

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Nezzie Rorie ADDRESS: 1211 E. Chase St

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. E982X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia complicating stabwound of head

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Feb. '67	Head injury	Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1211 E. Chase Street 10-01

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 2-11-67 11:20 P. m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Stabbed during altercation

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: November 30, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	Dec 1, 1967	Mt Auburn Cem	Westport Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 1 1967	Robert E. Farley M.D.	Milton E. Elickson	1129 N. Caroline St.

VS 151-REV. 1/1/65

N 850.2

1

W-420 67 11524

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11524

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROMAN P. WELLS

2. DATE AND HOUR PRONOUNCED DEAD: November 27, 1967 6:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): CHASE, Md. 53-00

D. STREET ADDRESS (If rural, give location): 7314 Linden Avenue

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: Feb 14 1937

9. AGE (In years last birthday): 30

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jesse Lion Wells

14. MOTHER'S MAIDEN NAME: Irene Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Ella Mae Wells — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E 819.4

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Steering W heel Injury of Chest

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Earls Road - 600 ft. North of Eastern Avenue 53-00

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 11/27/67 5:15 P.M.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Driver of car - went out of control - struck a concrete bridge

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 11/28/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: Dec 1/67

23C. NAME of CEMETERY or CREMATORY: Sharp St. Cemetery

23D. LOCATION (City, town, or county) (State): Westport Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967

24B. NAME OF REGISTRAR: Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR: Zorah T. Elickova — ADDRESS: 1129 N. Carlton St.

VS 151-REV. 1/1/65

N 862.2

D-120

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11525

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANDREW DAVIS

2. DATE AND HOUR OF DEATH: 11/28/67 8 30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2022 E. PRESTON ST.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTo
D. STREET ADDRESS (If rural, give location): 2022 E. PRESTON ST.

8-04

5. SEX: M.
6. RACE: C.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 6/6/02
9. AGE (In years last birthday): 65
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELECTRIC WELDER
10B. KIND OF BUSINESS OR INDUSTRY: BETH. STEEL
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: BOLUS DAVIS
14. MOTHER'S MAIDEN NAME: BETTY FIELDS.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): XE
(If yes, give war or dates of service): 7/17/18 - 8/21/19
16. SOCIAL SECURITY NO.: 719-10-7029
17. INFORMANT: LESSIE F. DAVIS
ADDRESS: 2022 E. PRESTON

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 331 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro Vascular Accid. — Several hours

DUE TO

(B) Generalized Atherosclerosis — 5 yrs

DUE TO

(C) Essential Hypertension — 10 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Mar 1950 to Nov 1967, that (I) (~~we~~) last saw the deceased alive on 15 Nov 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Simon A Carty
M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 30 Nov 67
23C. PHYSICIAN'S NAME (Type): Simon A Carty M.D.
23D. ADDRESS: 4215 Park Heights Ave City

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/1/67
24C. NAME of CEMETERY or CREMATORY: BALTo NATIONAL
24D. LOCATION (City, town, or county) (State): 5501 FREDERICK AVE.

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Joseph G. Lock Jr.
ADDRESS: 1304 N. Central Ave

VS 150-REV. 1/1/65

1

C-620 67 11526

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11526

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BING CROSBY CROSS

2. DATE AND HOUR PRONOUNCED DEAD: November 27, 1967 9:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 92 Baltimore City Jail

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-38

D. STREET ADDRESS (If rural, give location): 3515 Forrest Park Avenue

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: June 5 1932

9. AGE (In years last birthday): 35

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bell. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wesley Cross

14. MOTHER'S MAIDEN NAME: Georgianna

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Georgianna Swann ADDRESS: 3515 Forest Park Ave.

MEDICAL CERTIFICATION

1B. 292.6

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Sickle Cell Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF M.D. Werner U. Spitz

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 11/27/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: Dec 2/67

23C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem

23D. LOCATION (City, town, or county) (State): Westport Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967

24B. NAME OF REGISTRAR: Robert E. Farber M.D.

24C. FUNERAL DIRECTOR: Donald T. Erickson ADDRESS: 1129 N. Carrollton St

VS 151-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B-653 67 11527

M.E. CASE NO. 48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11527

1. NAME OF DECEASED (Type or Print): Charles Burnette

2. DATE AND HOUR OF DEATH: 11-30-67 | 3:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Md 11-02
D. STREET ADDRESS (If rural, give location): 1310 Mt Royal Ave

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): X
8. DATE OF BIRTH: 6-3-89
9. AGE (In years last birthday): 78
If Under 1 Yr. Months: Days | If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Shoemaker
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY: U. S. A

13. FATHER'S NAME: Domenic Burnette
14. MOTHER'S MAIDEN NAME: Mary ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-18-6078A
17. INFORMANT: ~~XXXXXXXXXXXX~~ Mrs Agnes Castillo
ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute Agranulocytosis — ? days
DUE TO
(B) Arteriosclerotic Cardiovascular disease — years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-29 1967 to 11-30 1967, that (I) (we) last saw the deceased alive on 11-30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: L. Kemper Owens M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 11-30-67
23C. PHYSICIAN'S NAME (Type): L. KEMPER OWENS M.D.
23D. ADDRESS: 1

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/4/67
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 1 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Leonard J Ruck Inc. 5305 Harford Rd
ADDRESS

VS 150-REV. 1/1/65

5-1621

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11528 Registered No. 67 11528

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARY SPIERS

2. DATE AND HOUR OF DEATH: 11/28/67 11 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MD. B. COUNTY: C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 10-01 D. STREET ADDRESS (If rural, give location): 1200 VALLEY ST.

5. SEX: F 6. RACE: NEGRO 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WID. 8. DATE OF BIRTH: 7/22/79 9. AGE (In years last birthday): 88 If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 10B. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): VIRGINIA 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: DENNIS DIGGS 14. MOTHER'S MAIDEN NAME: CATHERINE CONTRE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): 16. SOCIAL SECURITY NO.: None 17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 442X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Heart failure (congestive) — minutes

DUE TO

(B) Hypertensive Cardiovascular Disease — ? years

DUE TO

(C) Arteriolar Nephrosclerosis — ? years

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/28 1967 to 11/28 1967, that (I) (we) last saw the deceased alive on 11/28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kenneth Stern M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): KENNETH STERN M.D. 23D. ADDRESS: MERCY Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: Dec 2 67 24C. NAME of CEMETERY or CREMATORY: Cathedral 24D. LOCATION (City, town, or county) (State): Baltimore

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967 25B. NAME OF REGISTRAR: Robert E. Fahrney 25C. FUNERAL DIRECTOR: Philip Henry Sons ADDRESS: 2024 Orleans St

VS 150-REV. 1/1/65

0-23 6 1

BIRTH NO. 67 11529

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11529

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): OSTERLOH, HENRY (NMI)

2. DATE AND HOUR OF DEATH: 11/29/67 12:05 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE CITY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21-02
D. STREET ADDRESS (If rural, give location): 1175 SARGENT STREET SARGEANT

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: 4/9/1892
9. AGE (In years last birthday): 75
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THEODORE OSTERLOH
14. MOTHER'S MAIDEN NAME: MARGARET GEBHART

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES (If yes, give war or dates of service): 5/30/17 TO 9/27/19
16. SOCIAL SECURITY NO.: 219-12-86-87
17. INFORMANT: V.A. HOSPITAL RECORDS ADDRESS: 3900 LOCH RAVEN BLVD, BALTO, MD. 21218

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.): ARTERIOSCLEROTIC HEART DISEASE — UNKNOWN

(A) DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: CEREBRAL ARTERIOSCLEROSIS AND ARTERIOLAR NEPHROSCLEROSIS. — UNKNOWN

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that XX (this hospital) attended the deceased from 11/29/67 19 to 11/29/67 19, that X (we) last saw the deceased alive on 11/29/67 19 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) XXXXX view the body after death.

23A. SIGNATURE — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X
23B. DATE SIGNED: 11/30/67
23C. PHYSICIAN'S NAME (Type): RALPH H. TWINING, M.D. RH Twining
23D. ADDRESS: 3900 LOCH RAVEN BLVD, V.A. HOSPITAL, BALTIMORE, MD. 21218

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 2 Dec. 67
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Kirkley Funeral Home, Glen Burnie, ADDRESS

VS 150-REV. 1/1/65

1

5-536

67 11530 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11530

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MELVIN G. SAUNDERS

2. DATE AND HOUR PRONOUNCED DEAD: November 27, 1967 10:50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Union Memorial Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-03

D. STREET ADDRESS (If rural, give location): 4609 Freedom Way West # 21213.

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: June 3, 1921

9. AGE (In years last birthday): 46

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Asst. Manager

10B. KIND OF BUSINESS OR INDUSTRY: Pep Boys Co.

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Saunders

14. MOTHER'S MAIDEN NAME: Ada Westerman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.: 220-03-5952

17. INFORMANT: Marianna E. Saunders

ADDRESS: Same.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

E981 X

(A) Gunshot Wound of Head

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Bar

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3408 Belair Rd. - Vilma Bar 27-01

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 11/27/67 10:20 P. m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Subj. was a customer - shot during hold up

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

M.D. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [XX] ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 11/28/67

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12-1-67

23C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery

23D. LOCATION (City, town, or county) (State): 7225 Eastern Blvd., Ba. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

24B. NAME OF REGISTRAR: Robert E. Farkey M.D.

24C. FUNERAL DIRECTOR: Charles S. Feiler

ADDRESS: 901 S. Conkling St. Balto., 21224, Md.

VS 151-REV. 1/1/65

N856.4

1
A-352

67 11531 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11531

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MILDRED ADAMS

2. DATE AND HOUR PRONOUNCED DEAD: November 26, 1967 2:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 2822 Guilford Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-03

D. STREET ADDRESS (If rural, give location): 2822 Guilford Avenue

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: Feb. 25, 1914

9. AGE (In years last birthday): ~~AGE~~ 53

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): stenographer at

10B. KIND OF BUSINESS OR INDUSTRY: Fort Meade

11. BIRTHPLACE (State or foreign country): Balto., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Kirwan

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): yes

(If yes, give war or dates of service): W. W. II

16. SOCIAL SECURITY NO.: 216-01-9865

17. INFORMANT: Mr. Gus Adams

ADDRESS: 2822 Guilford Ave.

MEDICAL CERTIFICATION

1B. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Recent myocardial infarct

DUE TO

(B) Arteriosclerotic cardiovascular disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

DATE SIGNED: November 26, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 11/30/67

23C. NAME of CEMETERY or CREMATORY: Baltimore National

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

24B. NAME OF REGISTRAR: Robert E. Farkyma

24C. FUNERAL DIRECTOR: Mitchell-Wiedefeld Home

ADDRESS: 6500 York Road Balto., Md. 21212

VS 151-REV. 1/1/65

J-5201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11532 Registered No. 67 11532

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Cecil ~~Cecilia~~ Mae Jones

2. DATE AND HOUR OF DEATH: 11-29-67. 12:12 P. M.

CERTIFICATE AMENDED 12-22-67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21238 24-03
D. STREET ADDRESS (If rural, give location): 1114 Riverside Ave

5. SEX: F.
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 9-30-1905
9. AGE (In years last birthday): ~~63~~ 62
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ga.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Levi ~~White~~ Haney
14. MOTHER'S MAIDEN NAME: Luha

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Carcinoma of the lung, type undetermined — greater than 4 months

(B) DUE TO:

(C):

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING I.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No.
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 10-30 1967 to 11-29 1967, that ~~(I)~~ (we) last saw the deceased alive on 11-29 1967 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John Albert Bigbee, M.D. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 11-29-67

23C. PHYSICIAN'S NAME (Type): John ALBERT Bigbee MD
23D. ADDRESS: 1213 Light Street.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial - Removal
24B. DATE: 12/4/67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State): Bluefield, W. Va.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR: Wm. J. Tuchner Sons — ADDRESS: Balto, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V.S. 153 12-22-67 M.H.

B-2461

67 11533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11533

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): John E. Bassler

2. DATE AND HOUR OF DEATH: Nov 28, 1967 | 5.02 p. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 Sinai Hospital of Balto

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21-18

D. STREET ADDRESS (If rural, give location): 5001 Litchfield Ave. # 15

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Dec 20, 1892

9. AGE (In years last birthday): 74

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Security Man

10B. KIND OF BUSINESS OR INDUSTRY: Hauswald Bakery

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John W. Bassler

14. MOTHER'S MAIDEN NAME: Lena Brown.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Charlotte M. Bassler.

ADDRESS: 5001 Litchfield Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 1621 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO: Pulmonary hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

(B) DUE TO: Bronchogenic Ca. — 7 months

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 1967 to Aug 10 1967, that (I) (~~we~~) last saw the deceased alive on Aug 10 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Seymour A. Rubin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 11/30/67

23C. PHYSICIAN'S NAME (Type): Seymour A. Rubin M.D.

23D. ADDRESS: 5415 Park Heights Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/2/67

24C. NAME of CEMETERY or CREMATORY: Saters Cemetery

24D. LOCATION (City, town, or county) (State): Balto Co, Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Austin E. Donovan

ADDRESS: 3818 Roland Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-364

67 11534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11534

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): STERLING, NORRIS

2. DATE AND HOUR OF DEATH: 11/29 '67 | 10 10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 UNION MEMORIAL HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: CATONSVILLE

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto Co 53-00

D. STREET ADDRESS (If rural, give location): 206, S. SYMINGTON AVE.

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 05-15-06

9. AGE (In years last birthday): 62

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MANAGER

10B. KIND OF BUSINESS OR INDUSTRY: TRANSFER & STORAGE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Not known

14. MOTHER'S MAIDEN NAME: Not known

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: 212-09-1586

17. INFORMANT: Chart

ADDRESS:

MEDICAL CERTIFICATION

1B. 330 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Cerebral Hemorrhage

DUE TO

(B) Aneurysm of (L) Middle Cerebral Artery

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 14 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/15 1967 to 11/29 '67 19, that (I) (we) last saw the deceased alive on 11/29 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: M. Petursson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 11/29 '67

23C. PHYSICIAN'S NAME (Type): MAGNUS K. PETURSSON, M.D. M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-2-67

24C. NAME of CEMETERY or CREMATORY: Lorraine Cemetery

24D. LOCATION (City, town, or county) (State): Woodlawn Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Farkuna

25C. FUNERAL DIRECTOR: Farley Cavanaugh & Catonsville Md

ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-6301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11535 Registered No. 67 11535

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): TADEUSZ SKWIRUT

2. DATE AND HOUR OF DEATH: December 1, 1967 | 1:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 410 S. Washington Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 2-01

D. STREET ADDRESS (If rural, give location): 410 S. Washington Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 3/5/1894

9. AGE (In years last birthday): 73

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor

10B. KIND OF BUSINESS OR INDUSTRY: Clothing Mfg.

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walenty Skwirut

14. MOTHER'S MAIDEN NAME: Jadwiga Nyzio

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: 216-07-4288

17. INFORMANT: Mrs. Martha Serio, 6721 Brentwood Ave

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

260 X

(A) Coronary Occlusion

DUE TO (B) Hypertensive C.V.D.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) Arteriosclerosis Gen. Aged.

(C) Diabetes Mellitus

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from June 19 67 to 12/1/ 19 67, that (I) (~~we~~) last saw the deceased alive on 11/30/ 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Julius F. Jawoski M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/2/67

23C. PHYSICIAN'S NAME (Type): M. F. JAWORSKI M.D.

23D. ADDRESS: 2711 Carlton Ave

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/5/67

24C. NAME of CEMETERY or CREMATORY: St. Stanislaus

24D. LOCATION (City, ~~Town or County~~, State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Falkner

25C. FUNERAL DIRECTOR: M.F. SADOWSKI & SONS, 1808 EASTERN AVE

ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452

BIRTH NO. 67 11536

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11536

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bad burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): HARRY M. WILLIAMS

2. DATE AND HOUR OF DEATH: 11/28/67 11-20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HOUSE IN PINES-BELVEDERE-NURSING HOME 90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 16-03

D. STREET ADDRESS (If rural, give location): 608 N. Gilmor Street

5. SEX: M

6. RACE: C

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Dec 25, 1891

9. AGE (In years last birthday): 75

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Long Shoreman

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William H. Williams

14. MOTHER'S MAIDEN NAME: Ida Dorsey

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes

(If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 212-09-6609

17. INFORMANT: Richard L. Williams

ADDRESS: 908 N. Monroe

MEDICAL CERTIFICATION

1B. 177 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) CARCINOMATOSIS

DUE TO

(B) CARCINOMA OF PROSTATE

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 5 7

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that I (this hospital) attended the deceased from 11/3 1967 to 11/28 1967, that I (we) last saw the deceased alive on 11/28 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE: Raymond T. Caplan M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 11/28/67

23C. PHYSICIAN'S NAME (Type): Raymond Caplan M.D.

23D. ADDRESS: 1010 St. Paul St. 72

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/1/67

24C. NAME of CEMETERY or CREMATORY: Balto. Nat. Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Fahey

25C. FUNERAL DIRECTOR: W C Mach

ADDRESS: 928 Ernon Ave

VS 150-REV. 1/1/65

B-320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11537

Registered No. 67 11537

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CLARK BATES

2. DATE AND HOUR OF DEATH: 11/30/67 | 3:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp. Balt. Md.

37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-08

D. STREET ADDRESS (If rural, give location): 1902 Kennedy Ave

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 3/16/18

9. AGE (In years last birthday): 49

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): disabled

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Washington, Ga.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Bates

14. MOTHER'S MAIDEN NAME: Charlene Wadley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 256-01-9292

17. INFORMANT: Mrs Willie Bates

ADDRESS: 1902 Kennedy Ave

MEDICAL CERTIFICATION

18. 260 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Myocardial Infarction — 30 min.

DUE TO

(B) Vomiting & Aspiration — minutes

DUE TO

(C) Diabetes Mellitus — years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11/24/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Gangrene

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/2 19 67 to 11/30 19 67, that (I) (we) last saw the deceased alive on 11/30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. M. Thorne M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 11/30/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/4/67

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Fadeyev

25C. FUNERAL DIRECTOR: Wm. C. March

ADDRESS: 928 E. North Ave

VS 150-REV. 1/1965

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-522

BIRTH NO. 67 11538

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11538

1. NAME OF DECEASED (Type or Print): MANCUSO, IMOGENE

2. DATE AND HOUR OF DEATH: 12-1-67 | 1 45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): NORTH CHARLES GEN. HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 26-36

D. STREET ADDRESS (If rural, give location): 6543 Parnell Av. Balto. 21222

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED.

8. DATE OF BIRTH: 8-21-26

9. AGE (In years last birthday): 41

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ARKANSAS

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: A.N. BENNET

14. MOTHER'S MAIDEN NAME: PEARL MERIDETH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-20-9765

17. INFORMANT: CHART

ADDRESS: NORTH CHARLES G.H.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

330 X

(A) Subarachnoid Hemorrage

DUE TO

(B) Hypertension

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-22 1967 to 12-1 1967, that (I) (we) last saw the deceased alive on 12-1- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12-1-67

23C. PHYSICIAN'S NAME (Type): G. de la TORRE M.D.

23D. ADDRESS: NORTH CHARLES GEN. HOSP.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/4/67

24C. NAME of CEMETERY or CREMATORY: ST. STANISLAUS

24D. LOCATION (City, town, or county) (State): BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: W. Brooks Bradley

ADDRESS: W. BROOKS BRADLEY, DUNDALK, MD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

C-432 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11539

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11539

1. NAME OF DECEASED (Type or Print): CHILDS, GEORGE LEROY

2. DATE AND HOUR OF DEATH: November 30, 1967 | 6 pm M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 4124 Moravia Road Baltimore, Maryland 21206

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-01

D. STREET ADDRESS (If rural, give location): 4124 Moravia Road, Balto., Md. 21206

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	white	married	1/26/06	61 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Zerox Operator	State of Md.	Balto., Md.	U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Betty Childs

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-01-7148

17. INFORMANT: Luella Childs, wife, above (nee Everett)

ADDRESS:

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute coronary thrombosis — 11-30-67

DUE TO

(B) arteriosclerotic coronary — 1962 - 1967

DUE TO

heart disease

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov 3 1962 to Nov 30 1967, that (I) (we) last saw the deceased alive on Oct 26 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Charles M Kerr M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Dec 1, 1967

23C. PHYSICIAN'S NAME (Type): Dr. Charles M. Kerr M.D.

23D. ADDRESS: 6801 Belair Road

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/4/67	Gardens of Faith Cemetery	Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Schimunek Funeral Home

ADDRESS: 3331 Brehms Lane #13

VS 150-REV. 1/1/65

S-365

BIRTH NO. 67 11540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11540

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MR. GEORGE F. STRINE

2. DATE AND HOUR OF DEATH: 11/30/67 | 2:15 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BON SECOURS HOSPITAL

34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO.

28-04

D. STREET ADDRESS (If rural, give location): 120 S. TREMONT RD

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 5/16/11

9. AGE (In years last birthday): 56

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMEN

10B. KIND OF BUSINESS OR INDUSTRY: HARDWARE

11. BIRTHPLACE (State or foreign country): BALTO. MD.

12. CITIZEN OF WHAT COUNTRY? YES

13. FATHER'S NAME: GEORGE STRINE

14. MOTHER'S MAIDEN NAME: MARY RONEKE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-10-5570

17. INFORMANT: Mrs. Alice E. Strine

ADDRESS: Balto. Md. 21229 120 S. Tremont Rd

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 260 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Two Days

DUE TO

(B) Diabetes mellitus — Two Years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov 28 1967 to Nov 30 1967, that (I) (we) last saw the deceased alive on 2:15 AM Nov 30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S. W. Hong M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: NOV 30 '67

23C. PHYSICIAN'S NAME (Type): SOO WOONG HONG M.D.

23D. ADDRESS: BON SECOURS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Dec. 2, 1967

24C. NAME of CEMETERY or CREMATORY: Meadowridge Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Albert E. Fackenthal

25C. FUNERAL DIRECTOR: G. Truman Schwab

ADDRESS: 3512 Frederick Ave. Balto. Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-1001

BIRTH NO. 67 11541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11541

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MINNIE F. DE HOFF

2. DATE AND HOUR OF DEATH: Nov. 29, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 507 Wellesley St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 20-06

D. STREET ADDRESS (If rural, give location): 507 Wellesley St.

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Oct. 15, 1888

9. AGE (In years last birthday): 79

If Under 1 Yr. Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Frederick Barth

14. MOTHER'S MAIDEN NAME: Elizabeth Kahler

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-30-4441 A

17. INFORMANT: Balto. Md. 21228

ADDRESS: Mrs. Daniel Freedenburg 414 Greenlow Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I 1B. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ASCVD — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from July 1950 to Nov 29 1967, that (I) (~~we~~) last saw the deceased alive on Nov. 27 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~didn't~~) view the body after death.

23A. SIGNATURE: Earl Pass M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 11-29-67

23C. PHYSICIAN'S NAME (Type): I. EARL PASS M.D.

23D. ADDRESS: 400 Wellesley

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Dec. 1, 1967

24C. NAME of CEMETERY or CREMATORY: Western Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Falkenna

25C. FUNERAL DIRECTOR: G. Truman Schwab

ADDRESS: 3512 Frederick Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-4501

BIRTH NO. 67 11542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11542

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HELM, JOHN SLOAN

2. DATE AND HOUR OF DEATH: NOVEMBER 28, 1967 | 3:42 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MARYLAND 21229

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 21228 Balto Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 2021 ROLLINGWOOD RD. Rollingwood Rd.

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 06-13-20
9. AGE (In years last birthday): 47
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TECHNICIAN
10B. KIND OF BUSINESS OR INDUSTRY: SURFACE DIV. WESTINGHOUSE
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: FRANKLIN H. Helm
14. MOTHER'S MAIDEN NAME: ESTELLA SLOAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES
(If yes, give war or dates of service): W-WAR 2
16. SOCIAL SECURITY NO. 213-14-2456
17. INFORMANT: RECORDS ST. AGNES HOSPITAL
ADDRESS: CATON & WILKENS BALTIMORE, MD. 21229

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 193.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) astrocytoma, brain
DUE TO
(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from OCTOBER 27 19 67 to NOVEMBER 28 19 67, that (X) (we) last saw the deceased alive on NOVEMBER 28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jaime V. del Pilar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 11/28/67

23C. PHYSICIAN'S NAME (Type): JAIME V. DEL PILAR M.D.
23D. ADDRESS: CATON & WILKENS AVES., BALTO., MD. 212-29

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-1-67
24C. NAME of CEMETERY or CREMATORY: Balto National Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md

25A. DATE REC'D BY HEALTH DEPT: DEC 4 1967
25B. NAME OF REGISTRAR: Robert E. Tarkuna
25C. FUNERAL DIRECTOR: Farley-Cromwell
ADDRESS: 711 Caton Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
P-626

67 11543 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11543

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALBERT PARKER

2. DATE AND HOUR PRONOUNCED DEAD: November 30, 1967 7:07 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-05
D. STREET ADDRESS (If rural, give location): 419 E. Federal Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Aug. 4, 1926
9. AGE (In years last birthday): 41
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brick layer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Accomac Co. Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert Parker
14. MOTHER'S MAIDEN NAME: Mary E. Bailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W.W. 2
16. SOCIAL SECURITY NO.: 216-20-1994
17. INFORMANT: Evelyn Parker
ADDRESS: 419 E. Federal St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic heart disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: November 30, 1967

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial
23B. DATE: Dec. 4, 1967
23C. NAME of CEMETERY or CREMATORY: Balto. National Cem.
23D. LOCATION (City, town or county) (State): Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Williams Funeral Home
ADDRESS: 3199 Schroeder St.

VS 151-REV. 1/1/65

M-422

BIRTH NO. 67 11544

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11544

1. NAME OF DECEASED (Type or Print): JOSEPH MALISZEWSKI

2. DATE AND HOUR OF DEATH: December 2, 1967 | 7:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 116 S. Broadway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 3-01
D. STREET ADDRESS (If rural, give location): 116 S. Broadway

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 1/19/1899
9. AGE (In years last birthday): 68
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stevedore (Ret.)
10B. KIND OF BUSINESS OR INDUSTRY: Handling Cargo
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walenty Maliszewski
14. MOTHER'S MAIDEN NAME: Josephine Gromadzki

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: 215-03-0669A
17. INFORMANT: Mrs. Martha Maliszewski
ADDRESS: 116 S. Broadway

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ARTERIOSCLEROTIC HEART DIS. — 5 yrs
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/19 1957 to 12/2 1967, that (I) (we) last saw the deceased alive on 12/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Irwin B. Kaplan M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/4/67
23C. PHYSICIAN'S NAME (Type): IRWIN B. KAPLAN M.D.
23D. ADDRESS: 129 S. BROADWAY

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/5/67
24C. NAME of CEMETERY or CREMATORY: St. Stanislaus
24D. LOCATION (City, ~~Town or County~~) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
25B. NAME OF REGISTRAR: R. Scott E. Tankersley
25C. FUNERAL DIRECTOR: M.F. SADOWSKI & SONS
ADDRESS: 1808 EASTERN AVE

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-420

67 11545 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11545

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CATHERINE S. KOWALIK (also K/as Katarzyna S.)

2. DATE AND HOUR PRONOUNCED DEAD: December 2, 1967 | 9:10 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 529 S. Chapel St. D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-03
D. STREET ADDRESS (If rural, give location): 529 S. Chapel Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Widowed	11/1/1891	76				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	-	Poland	Poland

13. FATHER'S NAME: Vincent Surowski

14. MOTHER'S MAIDEN NAME: Eva Sokol

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
-	-	217-09-4733	Mr. Ignatius Daniel Kowalik	529 S. Chapel St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 3, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City or town) (County) (State)
Burial	12/6/67	Holy Rosary	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 4 1967	Robert E. Barkey	M.F.SADOWSKI & SONS	1808 EASTERN AVE

VS 151-REV. 1/1/65

1
F-230

67 11546

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 11546

BIRTH NO.

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GLADYS W. FOSSETT

2. DATE AND HOUR PRONOUNCED DEAD: December 1, 1967 7:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1831 Pressman Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-02

D. STREET ADDRESS (If rural, give location): 1831 Pressman Street

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: 5-23-09

9. AGE (In years last birthday): 58

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): N.J.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: Emily Warner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218205648

17. INFORMANT: Sarah Cooper

ADDRESS: 510 E. 21th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.0

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: December 1, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12-4-67

23C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Pk.

23D. LOCATION (City, town, or county) (State): Arbutus, Maryland

24A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

24B. NAME OF REGISTRAR: Robert E. Fahrney

24C. FUNERAL DIRECTOR: Kelson Funeral Home

ADDRESS: 1348 Calhoun St.

VS 151-REV. 1/1/65

S-366

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11547

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Patsy Strayhorn

2. DATE AND HOUR OF DEATH: 11-30-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 743 W. Saratoga Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: X

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 4-02

D. STREET ADDRESS (If rural, give location): 743 W. Saratoga Street

5. SEX: Female

6. RACE: Negroid

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 9-8-04

9. AGE (In years last birthday): 63

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Alexander

14. MOTHER'S MAIDEN NAME: Mary

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Haletha Jones ADDRESS: 4408 Bellevue Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

420.1

(A) Arteriosclerotic occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

(B) Cerebrovascular disease Hypertension

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 5-8 1963 to 11-30 1967, that (I) (~~we~~) last saw the deceased alive on 11-16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: William H Watts M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-1-67

23C. PHYSICIAN'S NAME (Type): William H Watts M.D.

23D. ADDRESS: 5754 Arlington Ave

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-4-67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Pk.

24D. LOCATION (City, town, or county) (State): Arbutus, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Kelson Funeral Home ADDRESS: 1348 Calhoun St.

VS 150-REV. 1/1/65

C-45-2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11548

Registered No. 67 11548

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SHELTON COLLINS

2. DATE AND HOUR OF DEATH: 12/2/67 | 6:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 25-32

D. STREET ADDRESS (If rural, give location): 2753 Bookert Drive

5. SEX: M

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 4-6-95

9. AGE (In years last birthday): 72

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian

10B. KIND OF BUSINESS OR INDUSTRY: Bowie College (R)

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Howard Collins

14. MOTHER'S MAIDEN NAME: Alverta ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Estelle Collins 2753 Bookert Drive

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.

DUE TO

(B) ASCVD — 10 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 12/2 1967 to 12/2 1967, that (I) ~~(we)~~ last saw the deceased alive on 12/2 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Zalman S. Agus M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/2/67

23C. PHYSICIAN'S NAME (Type): ZALMAN S. AGUS M.D.

23D. ADDRESS: University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/6/67

24C. NAME of CEMETERY or CREMATORY: MT. Auburn Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Sankey M.A.

25C. FUNERAL DIRECTOR: Joseph G. Locks Jr.

ADDRESS: 1304 N. Central Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452

67 11549 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11549

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JESSE WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD: November 30, 1967 2:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): OO 1830 N. Dallas Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-05

D. STREET ADDRESS (If rural, give location): 1830 N. Dallas Street

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 4/24/03

9. AGE (In years last birthday): 64

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK

10B. KIND OF BUSINESS OR INDUSTRY: HAT Co.

11. BIRTHPLACE (State or foreign country): BALTO. Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Richard Williams

14. MOTHER'S MAIDEN NAME: MARY E. De Shields

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Thornton Williams ADDRESS: 1830 N. DALLAS St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

420.0

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Chas S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: December 1, 1967

23A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23B. DATE: 12/4/67

23C. NAME of CEMETERY or CREMATORY: MT. CALVARY

23D. LOCATION (City, town, or county) (State): A.A. County, Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

24B. NAME OF REGISTRAR: Robert E. Lankford

24C. FUNERAL DIRECTOR: Joseph G. Lockie Jr. ADDRESS: 1304 N. Carrollton

VS 151-REV. 1/1/65

1

P-362 67 11550

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11550

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLES H. PATTERSON

2. DATE AND HOUR PRONOUNCED DEAD: November 26, 1967 | 7:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Maryland General Hospital

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-02

D. STREET ADDRESS (If rural, give location): 2004 Park Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Married	Sept. 28, 1923	44				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver		Montgomery Co. Md.	U.S.A.

13. FATHER'S NAME: Arthur Patterson

14. MOTHER'S MAIDEN NAME: Alice M. Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW II

16. SOCIAL SECURITY NO. 219-14-8896

17. INFORMANT: Mrs. Dorothy Patterson ADDRESS: 2004 Park Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E 982X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Stab Wound of Chest

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 26

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2004 Park Avenue 13-02

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 11/26/67 7:00 P. - 7:25 P. m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Subj. stabbed during argument

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [XX]

ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 11/27/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county)	(State)
Burial	Dec. 1, 1967	Baltimore National Cem.	5501 Sudbrook Lane Baltimore	Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 4 1967	Robert E. Farley M.D.	Joseph L. Russ	2222 W. North Ave. Baltimore, Md.

VS 151-REV. 1/1/65

N 875.2

R-262

BIRTH NO. 67-24225 67 11551

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11551 4

1. NAME OF DECEASED (Type or Print): Rogers, Baby Boy

2. DATE AND HOUR OF DEATH: 11/29/67 | 3:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 9-07

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 2704 THE ALAMEDA

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	N C	NEVER MARRIED	11/29/67				7	30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ELLIOTT ROGERS

14. MOTHER'S MAIDEN NAME: SARAH WILKINS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 762.5 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypoxia — 2½ hrs

DUE TO

(B) Hyaline Membrane Disease — 5½ hrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Prematurity -

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/29 1967 to 11/29 1967, that (I) ~~(We)~~ last saw the deceased alive on 11/29 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. William Flynt M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 11/29/67

23C. PHYSICIAN'S NAME (Type): J. WILLIAM FLYNT M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): CREMATION

24B. DATE: 11-30-67

24C. NAME of CEMETERY or CREMATORY: JOHNS HOPKINS HOSPITAL

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL

ADDRESS:

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-640 67 11552

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11552

1. NAME OF DECEASED (Type or Print): Vivian Farley VIVIAN LOUISE FARLEY

2. DATE AND HOUR OF DEATH: 11-30-67 1:15 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Balto Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 21222 53-00

D. STREET ADDRESS (If rural, give location): 7861 St. Clare La.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 12-12-13

9. AGE (In years last birthday): 53

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Samuel B. Gunter

14. MOTHER'S MAIDEN NAME: Verdie Wright

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Norman L. Gunter ADDRESS: 7861 St. Clair Lane Balto. Md. 212 22

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO: Arteriosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-20 1967 to 11-30 1967, that (I) (we) last saw the deceased alive on 11-30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W L Boddie M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 11-30-67

23C. PHYSICIAN'S NAME (Type): WILLIAM L. BODDIE M.D.

23D. ADDRESS: Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/4/67

24C. NAME of CEMETERY or CREMATORY: Maury Cemetery

24D. LOCATION (City, town, or county) (State): Richmond Virginia

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Tankey M.D.

25C. FUNERAL DIRECTOR: HENRY SANDER & SONS INC. ADDRESS: BALTIMORE MARYLAND 21213

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released by Med Examiner

L-200 BIRTH NO. 67 11553

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11553

1. NAME OF DECEASED (Type or Print): LEWIS, MAE

2. DATE AND HOUR OF DEATH: 12/1/67 9:16 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Balto Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): MILFORD 53-00
D. STREET ADDRESS (If rural, give location): 4110 BUCKINGHAM ROAD #07

42/40

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW
8. DATE OF BIRTH: MAY 17, 1893
9. AGE (In years last birthday): 74
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MOHAWK NEW YORK
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ORVILLE HELMER
14. MOTHER'S MAIDEN NAME: ELIZABETH PHIFER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 076-01-8191
17. INFORMANT: RICHARD C. LEWIS
ADDRESS: 4110 BUCKINGHAM RD MILFORD MD 21207

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 + 260 X

(A) M.I. or PULMONARY EMBOLISM — SEVERAL HOURS

DUE TO

(B) ASHD or RHEUMATIC HEART DISEASE

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DOA on 12/1 19 67 to 19 , that (I) (we) last saw the deceased alive on NEVER 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard Katon M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/1/67
23C. PHYSICIAN'S NAME (Type): RICHARD KATON M.D.
23D. ADDRESS: SINAI HOSPITAL OF BALTIMORE

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/4/67
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: HENRY SANDER & SONS INC.
ADDRESS: BALTIMORE, MARYLAND

VS 150-REV. 1/1/65

B-5321

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11554 Registered No. 67 11554

M.E. CASE NO. BENGTSON FRANK

1. NAME OF DECEASED (Type or Print): Bengtson Mr Frank

2. DATE AND HOUR OF DEATH: 11-29-67 7 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME AND HOSPITAL, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 530 Balto Co
C. CITY OR TOWN: Baltimore (If outside city limits, write RURAL and give township) 8167 Glen Garrie Rd
D. STREET ADDRESS (If rural, give location): 8167 Glen Garrie Rd (34)

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WID
8. DATE OF BIRTH: 9-30-88
9. AGE (In years last birthday): 79 If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Engineer
10B. KIND OF BUSINESS OR INDUSTRY: WRR
11. BIRTHPLACE (State or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217 14 0979
17. INFORMANT
ADDRESS

CAUSE OF DEATH

MEDICAL CERTIFICATION

1B. 581.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Bleeding from
DUE TO
(B) ruptured esophageal varices
DUE TO
(C) hepatic cirrhosis.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Nov 17 67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: bleeding
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-16-67 19 to 11-29- 19 67, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: L Kiraly M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 11-29-67
23C. PHYSICIAN'S NAME (Type): LAZLO KIRALY M.D.
23D. ADDRESS

24A. BURIAL CREMATION REMOVAL (Specify): Cremation
24B. DATE: 12/2/67
24C. NAME of CEMETERY or CREMATORY: Greenmount Cem-Crem.
24D. LOCATION (City, town, or county) (State): North Ave. & Greenmount

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: T. Fisher
ADDRESS: 1938 Eastern Ave.

VS 150-REV. 1/1/65

1
R-245

67 11555

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11555

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): VICTOR RAGLAND

2. DATE AND HOUR PRONOUNCED DEAD: December 2, 1967 M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1310 W. Lanvale St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1310 W. Lanvale St.

16-02

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days / Hours / Min.
Male	Colored	Married	4/21/1910	56	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sparrows Point		Halifax Co., Va.	U.S.A.

13. FATHER'S NAME: Alexander Ragland

14. MOTHER'S MAIDEN NAME: Laura Ragland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Gladys Ragland ADDRESS: 222 N. Stricker St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 422.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE Edward F. Wilson M.D.

EXAMINER'S NAME (Type) Edward F. Wilson, M.D.

DATE SIGNED December 3, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/6/67	Mt. Auburn Cemetery	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 4 1967	Robert E. Farley M.D.	Morton & Dyett Fun. H.	1701 Laurens

VS 151-REV. 1/1/65

G. 4001

Released by Medical Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11556 Registered No. 67 11556

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANDREW GALLOWAY

2. DATE AND HOUR OF DEATH: 11/29/67 7.35 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY: 1104, Edmondson Ave #23

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 1601

D. STREET ADDRESS (If rural, give location): 1104 Edmondson Ave

5. SEX: Male

6. RACE: NM

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 12/25/96

9. AGE (In years last birthday): 70 — If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Goldsboro, N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew Galloway, Sr.

14. MOTHER'S MAIDEN NAME: Helen Galloway

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Ethel Galloway — ADDRESS: 701 Rosedale St

CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

1B) 290.0

(A) Fracture Hip — ~~Cardiac Arrest due to Pulm Embolism~~

DUE TO

(B) Pyogenic Arthritis

DUE TO

(C) Septicaemia due to Chr. Renal failure, Heart Block

INTERVAL BETWEEN ONSET AND DEATH: 15 mts

CERTIFICATION APPROVED BY: [signature] M.D. CHIEF OR ASST. MEDICAL EXAMINER

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 11/16/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: PYOGENIC ARTHRITIS

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ ~~NOTIFIED~~ ☒

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1104 Edmondson Ave. 16-01

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) ~~(Hour)~~: June 5, 1967

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☒

21F. HOW DID INJURY OCCUR? Fell At Home

22. I certify that (I) (this hospital) attended the deceased from 11/10/67 19 to 11/29/67 19, that (I) (we) last saw the deceased alive on 11/29/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 11/29/67

23C. PHYSICIAN'S NAME (Type): R. BALASUBRAMANIAN M.D.

23D. ADDRESS: SINAI HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-4-67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Pk.

24D. LOCATION (City, town, or county) (State): Arbutus, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Farley

25C. FUNERAL DIRECTOR: Morton & Dyett F.H. — ADDRESS: 1701 Lawrence St

VS 150-REV. 1/1/65

N 520.0

W.4521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11557 Registered No. 67 11557

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAMS, CECIL

2. DATE AND HOUR OF DEATH: 1:00 PM 12/1/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 13-07

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 1007 W. 42nd St

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	N	Sep.	4/18/04	63				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GARMENT WORKER

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNK.

14. MOTHER'S MAIDEN NAME: UNK.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-05-7136

17. INFORMANT: Gertrude Ford ADDRESS: 2426 Harlem Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 581.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) UPPER G.I. HEMORRHAGE — 1/2 hour

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO gastric ulcer vs esophageal varices — ?

(C) DUE TO Cirrhosis & renal failure — ?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestive heart failure — ?

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/23 1967 to 12/1 1967, that (I) (we) last saw the deceased alive on 12/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/1/67

23C. PHYSICIAN'S NAME (Type): ALAN F. WOLF M.D.

23D. ADDRESS: c/o Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/5/67

24C. NAME of CEMETERY or CREMATORY: MT. AUBURN

24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: MORTON & DYETT ADDRESS: 1701 LAURENS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

(10) 1

D-263

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11558

Registered No. 67 11558

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): John M. Dukehart

2. DATE AND HOUR OF DEATH: November 30, 1967 | M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hospital DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 28-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 800 Brinkwood Rd.

46 99

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	Cauc.	Married	10/19/79	88				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chairman of the Board - Dukehart Co.

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Late - Adam Dukehart

14. MOTHER'S MAIDEN NAME: Late-Anna Warthen

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-32-3161

17. INFORMANT: Mrs. Rose E. Dukehart
ADDRESS: 800 Brinkwood Rd. -

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary thrombosis — 1/2 hour
DUE TO

(B) A.S.C.V.D. — year
DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 1946 to Nov 30 1967, that (I) (we) last saw the deceased alive on Nov 23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John C. Pound M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/1/67

23C. PHYSICIAN'S NAME (Type): John C. Pound M.D.

23D. ADDRESS: 3325 Frederick Av

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/4/67

24C. NAME of CEMETERY or CREMATORY: New Cathedral Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Witzke F. D. - 4101 Edmondson Av.
ADDRESS

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. H-322

M.E. CASE NO. 67 11559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11559

1. NAME OF DECEASED (Type or Print): Culbard R. Hutcheson

2. DATE AND HOUR OF DEATH: 12-1-67 10 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 4102 Roland Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-07
D. STREET ADDRESS (If rural, give location): 4102 Roland Ave.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 4-1-1891
9. AGE (In years last birthday): 76
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Executive
10B. KIND OF BUSINESS OR INDUSTRY: Metal Products
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Hutcheson
14. MOTHER'S MAIDEN NAME: Emma Royston

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-34-8289
17. INFORMANT: Mrs. Dorothy M. McGreevy ADDRESS: N.Y.C., N.Y.

MEDICAL CERTIFICATION

18. I 450.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — (A) Atherosclerosis

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-30 1967 to 12-1 1967, that (I) ~~(we)~~ last saw the deceased alive on 11-30 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: William G. Helfrich M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12-2-67
23C. PHYSICIAN'S NAME (Type): William G. Helfrich M.D.
23D. ADDRESS: 5006 Roland Ave., Balto., Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-5-67
24C. NAME of CEMETERY or CREMATORY: Jessops
24D. LOCATION (City, town, or county) (State): Balto. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co. ADDRESS: 4905 York Rd.

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. J-520 67 11560

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11560

1. NAME OF DECEASED (Type or Print): EDWARD W. JONES

2. DATE AND HOUR OF DEATH: 12/1/67 2:35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: A.A.Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 52-00
D. STREET ADDRESS (If rural, give location): 4924 BROOKLWOOD RD 21225

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 6/8/07
9. AGE (In years last birthday): 60
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BOOKKEEPER
10B. KIND OF BUSINESS OR INDUSTRY: BANKING
11. BIRTHPLACE (State or foreign country): BALTO, MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH JONES
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-14-5439
17. INFORMANT: M. MARGUERITE JONES
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) RENAL FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

DUE TO

(B) GEN. ASCYD

DUE TO

(C) CARDIAC FAILURE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11/10/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: PERIPH VAS DIS
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 10/29/67 19 to 12/1/67 19, that I (we) last saw the deceased alive on 12/1 1967 and that in my (our) opinion death occurred at the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE: Edward R. Cohen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/1/67
23C. PHYSICIAN'S NAME (Type): EDWARD R. COHEN M.D.
23D. ADDRESS: Sinai Hosp

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-4-67
24C. NAME of CEMETERY or CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: H.W.Jenkins & Sons Co.
ADDRESS: 4905 York Rd.

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-623

BIRTH NO.

67 11561

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11561

1. NAME OF DECEASED (Type or Print): GEORGE ELMER WRIGHT

2. DATE AND HOUR OF DEATH: 11-30-67 8:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 19-03

D. STREET ADDRESS (If rural, give location): 42 S STRICKER ST.

5. SEX: M

6. RACE: C NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SEPARATED

8. DATE OF BIRTH: 3-16-17

9. AGE (In years last birthday): 51

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES WRIGHT

14. MOTHER'S MAIDEN NAME: MARY GARRISON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: FRANKLIN SQUARE HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

286.5

(A) Electrolyte Imbalance

DUE TO

(B) Dehydration

DUE TO

(C) Malnutrition

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from NOV. 30 19 67 to NOV. 30 19 67, that (I) (we) last saw the deceased alive on NOV. 30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ruben V. Luna M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 11-30-67

23C. PHYSICIAN'S NAME (Type): RUBEN V. LUNA M.D.

23D. ADDRESS: FRANKLIN SQUARE HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/4/67

24C. NAME of CEMETERY or CREMATORY: Baltimore National

24D. LOCATION (City, town, or county) (State): Baltimore, Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Charles A. Rice

ADDRESS: 661 W Barrett

VS 150-REV. 1/1/65

M-200

BIRTH NO. 67 11562

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11562

1. NAME OF DECEASED (Type or Print): Irene Moss

2. DATE AND HOUR OF DEATH: 11-30-67 | 5:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21230 22-02

D. STREET ADDRESS (If rural, give location): 623 W. Conway St.

5. SEX: F.

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow.

8. DATE OF BIRTH: 2-16-07

9. AGE (In years last birthday): 60

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Will Leach

14. MOTHER'S MAIDEN NAME: Lizzie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MEDICAL CERTIFICATION

1B. 723.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Cervical Cord Compression

DUE TO

(B) Severe Cervical Spondylitis

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I)(this hospital) attended the deceased from 11-11 19 67 to 11-30 19 67, that (I)(we) last saw the deceased alive on 11-30 19 67 and that in (my)(our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-1-67

23C. PHYSICIAN'S NAME (Type): Consolador C. Palad, Jr. M.D.

23D. ADDRESS: 1213 Light St.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/5/67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn

24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Charles A. Rice

ADDRESS: 661 W. Baltimore St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

1
H-525

67 11563

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11563

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HARRIET HENSON

2. DATE AND HOUR PRONOUNCED DEAD: November 30, 1967 3:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 507 W. Mosher Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-02

D. STREET ADDRESS (If rural, give location): 507 W. Mosher Street

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: ?

9. AGE (In years last birthday): 68

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Howard Co, Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James Cooper

14. MOTHER'S MAIDEN NAME: Martha Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Justice, 604 W Biddle St

MEDICAL CERTIFICATION

1B. 422.1

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: December 1, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/4/67

23C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cemetry

23D. LOCATION (City, town, or county) (State): Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

24B. NAME OF REGISTRAR: Robert E. Faber, M.D.

24C. FUNERAL DIRECTOR: Adolphus Halstead

ADDRESS: 1206 W North Ave

VS 151-REV. 1/1/65

1967 0011 500

1
A-325

67 11564 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11564

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JESSE J. ATKINSON

2. DATE AND HOUR PRONOUNCED DEAD: December 2, 1967 | 2:25 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital

D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2585 Seamon Ave.

25-32

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored	MARRIED	FEB 11-1922	45				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER	Gas + Elec Co.	SELMA N.C.	U.S.

13. FATHER'S NAME: JAMES ATKINSON

14. MOTHER'S MAIDEN NAME: ELLA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.

17. INFORMANT: ALICE ATKINSON ADDRESS: 2585 SEAMON AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E981X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple gunshot wounds

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES	YES

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Tavern

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Joes Tap Room 1702 Chesapeake Ave.

21D. TIME OF INJURY (APPROX.) (Month) 12 (Day) 2 (Year) 67 (Hour) 1:50 a.m.

21E. INJURY OCCURRED: WHILE AT WORK [X] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR? Subject part-time bar tender

25-06

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 2, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	12/7/67	BALTO NATIONAL	BALTO MD

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 4 1967	[illegible]	Marshall P Hayes	638 N Gilmor St

VS 151-REV. 1/1/65

N 869.4

M-601

BIRTH NO. 67 11565

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11565

1. NAME OF DECEASED (Type or Print): Mary Murray

2. DATE AND HOUR OF DEATH: Dec. 3, 1967 | 1:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp. 38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, Md. 16-01
D. STREET ADDRESS (If rural, give location): 1013 BRANTLEY AVE

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: 11-8-73
9. AGE (In years lost birthday): ~~93~~ 94
If Under 1 Yr. Months: Days: Hours: If Under 24 Hrs. Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Wm ~~H.~~ Brown
14. MOTHER'S MAIDEN NAME: Eliza —

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: George de Ford
ADDRESS: 2002 Madison

MEDICAL CERTIFICATION

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute renal failure — 2 days
DUE TO
(B) Gram negative septicemia — 3 wks
DUE TO
(C) Sacral abscess w/ diverticulitis
(C) Atherosclerotic Heart Disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-4-67 19 to 12-3-67 19, that (I) (we) last saw the deceased alive on 12-3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John F Rogers M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12-4-67
23C. PHYSICIAN'S NAME (Type): JOHN F. ROGERS M.D.
23D. ADDRESS: University Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 12-7-67
24C. NAME of CEMETERY or CREMATORY: Union Methodist
24D. LOCATION (City, town, or county) (State): Chester Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Thomas A. Sayles
ADDRESS: 638 N. Gilmor

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. K-523 67 11566

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11566

1. NAME OF DECEASED (Type or Print): Percy Knight

2. DATE AND HOUR OF DEATH: 12-3-67 5:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: 18-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 27 N. CAREY ST.

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 8-6-91
9. AGE (In years last birthday): 75
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: App Knight
14. MOTHER'S MAIDEN NAME: Jennie Knight

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-09-2717
17. INFORMANT: Edith Knight Chart Record ADDRESS: 2617 Boone St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) C.V.A.

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-30 1967 to 12-3 1967, that (I) (we) last saw the deceased alive on 12-3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J.L. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12-3-67
23C. PHYSICIAN'S NAME (Type): J. Lee M.D.
23D. ADDRESS: FRANKLIN SQUARE HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-7-67
24C. NAME of CEMETERY or CREMATORY: Mount Calvary
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Halstead Funeral Home ADDRESS: 1206 W. North Ave.

VS 150-REV. 1/1/65

1

S-120 67 11567

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65-28368

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11567

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MELVANIA SAVAGE

2. DATE AND HOUR PRONOUNCED DEAD: November 29, 1967 | 12:15 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Provident Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 710 Dolphin Street

17-03

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Colored	Child	11/16/65	2				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child		Baltimore Md	U S A

13. FATHER'S NAME: Melvin Savage

14. MOTHER'S MAIDEN NAME: Mamie McCall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Mamie McCall, same — Mrs Mamie Savage, same — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. E916.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia

DUE TO Carbon Monoxide Poisoning

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	YES

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 710 Dolphin St. 3rd floor front

21D. TIME OF INJURY (APPROX.): (Month) 11 (Day) 28 (Year) 67 (Hour) 11:46 p.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Subject trapped in house fire

17-03

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: November 29, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/5/67	Mt Auburn Cemetery	Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 4 1967	Robert E. Farley, M.D.	Adolpjus	Halstead 1206 W North Ave

VS 151-REV. 1/1/65

N968.0

1

S-120 67 11568

BIRTH NO. 66-19216

19216

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11568

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): STEVEN SAVAGE

2. DATE AND HOUR PRONOUNCED DEAD: November 29, 1967 | 12:25 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Provident Hospital D.O.A.

39 99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

17-03

D. STREET ADDRESS (If rural, give location): 710 Dolphin Street

5. SEX: Male

6. RACE: Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Child

8. DATE OF BIRTH: 10/13/66

9. AGE (In years last birthday): 1

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Melvin Savage

14. MOTHER'S MAIDEN NAME: Mamie McCall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Mamie Savage ADDRESS: same

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. E916.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia

DUE TO Carbon Monoxide Intoxication

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

17-03

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 710 Dolphin Street. 3rd floor front

21D. TIME OF INJURY (APPROX.) (Month) 11 (Day) 28 (Year) 67 (Hour) 11:46 p.m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Subject trapped in house fire

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: November 29, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/5/67

23C. NAME of CEMETERY or CREMATORY: Mt Auburn Cemetry

23D. LOCATION (City, town, or county) (State): Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Adolphus Halsttead ADDRESS: 1206 W North Ave

VS 151-REV. 1/1/65

N 968.0

1

MILLER, Howard
126 1355

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M-460 67 11569

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11569

1. NAME OF DECEASED (Type or Print): Miller, Howard

2. DATE AND HOUR OF DEATH: 11/30/67 @ 8 40 AM. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL
33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1641 MILLIMAN STREET
T-05

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): S
8. DATE OF BIRTH: 7/
9. AGE (In years last birthday): 54
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 250-22-0290
17. INFORMANT: Chart, ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 153.8 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CARCINOMATOSIS — SYMPTOMS FOR 2-3 MONTHS.
DUE TO
(B) ADENOCARCINOMA OF COLON
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. LEFT HEMICOLECTOMY & COLOSTOMY — ABOUT 12 HRS.
COLOSTOMY - DOUBLE-BARREL

19A. DATE OF OPERATION: 11/20/67; 11/29/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: OBSTRUCTING CARCINOMA OF COLON
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/26 19 67 to 11/30 19 67, that (I) (we) last saw the deceased alive on 11/30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Mark B. Orringer M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 11/30/67
23C. PHYSICIAN'S NAME (Type): MARK B. ORRINGER M.D.
23D. ADDRESS: Johns Hopkins Hosp. Balt., Md. 21205

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/6/67
24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetry
24D. LOCATION (City, town, or county) (State): A A County Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
25B. NAME OF REGISTRAR: Robert E. Faber, M.D.
25C. FUNERAL DIRECTOR: Adolphus Halstead ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

1

M-624 67 11570

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11570

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FRED MARSHAL

2. DATE AND HOUR PRONOUNCED DEAD: November 26, 1967 2:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Johns Hopkins Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1520 N. Collington Avenue

8-04

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro		?	80				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Steel	North Carolina	U S A

13. FATHER'S NAME: Julius Marshall

14. MOTHER'S MAIDEN NAME: Polly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Julia Campbell, 2614 E Oliver St — ADDRESS

MEDICAL CERTIFICATION

1B. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: November 26, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/2/67	Mt Calvary Cemetry	A A County Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 4 1967	Robert E. Farley M.D.	A Halstead	1206 W North Ave

VS 151-REV. 1/1/65

1

M-240 67 11571

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 62-20729

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11571

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANTOINETTE MC CALL

2. DATE AND HOUR PRONOUNCED DEAD: December 1, 1967 2:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

17-03

D. STREET ADDRESS (If rural, give location): 710 Dolphin Street

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Child

8. DATE OF BIRTH: 8/9/62

9. AGE (In years last birthday): 5

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Raymond McCall

14. MOTHER'S MAIDEN NAME: Mamie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MRs Mamie Savage, same

ADDRESS:

MEDICAL CERTIFICATION

18. E916.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: Extensive burns of head, neck, trunk, and extremities

(A) DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 710 Dolphin Street 17-03

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 11-28-67 11:46 P.m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Found in burning building

22. I certify that I held on Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

DATE SIGNED: December 1, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/5/67

23C. NAME of CEMETERY or CREMATORY: Mt Auburn Ceketry

23D. LOCATION (City, town, or county) (State): B altimore MD

24A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

24B. NAME OF REGISTRAR: Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR: Adolphus Halstead

ADDRESS: 1206 W North Ave

VS 151-REV. 1/1/65

N946.2 6700 1593

A-450

BIRTH NO. 67 11572

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11572

1. NAME OF DECEASED (Type or Print): Arthur Allen

2. DATE AND HOUR OF DEATH: 11/26/67 | 9:55 a. m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

43

SOUTH BALTIMORE GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

25-32

D. STREET ADDRESS (If rural, give location): 2423 Seamon Avenue

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH: 7/10/14

9. AGE (In years last birthday): 53

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): ?

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Montque

14. MOTHER'S MAIDEN NAME: Anne

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Chart

ADDRESS

MEDICAL CERTIFICATION

1B. 581.1 + 260 X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Diabetes Mellitus

DUE TO

(B) Chronic Pancreatitis

DUE TO

(C) Laennec Cirhosis

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 10/23/67 19 to 11/26/67 19, that I (we) last saw the deceased alive on 11/26/67 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Donald M. Wood, M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 11/27/67

23C. PHYSICIAN'S NAME (Type): DONALD M. WOOD, M.D.

23D. ADDRESS: S.B.G.H. - 1213 Light Street

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/1/67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cemetry

24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: A Halstead

ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

R-500

BIRTH NO.

M.E. CASE NO. 67 11573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11573

1. NAME OF DECEASED (Type or Print): JULIAN A. REAMY

2. DATE AND HOUR OF DEATH: December 4, 1967. 5:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Gould Convalesarium

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21214 27-09

D. STREET ADDRESS (If rural, give location): 1911 Woodbourne Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Widowed	Feb. 5, 1881.	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Machinist	E.X. Hooper Co.	Virginia	USA

13. FATHER'S NAME: Fairfax Reamy

14. MOTHER'S MAIDEN NAME: Mary Oella Marders

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-09-2841A

17. INFORMANT: Mrs. W. Lester Davis, Box 35, Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — 331 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4-6 wk.

DUE TO

(B) Cerebral Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Myocardial Infarction

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Nov. 6 1967 to Dec. 4 1967, that (I) (~~we~~) last saw the deceased alive on Dec. 3 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Stephen Toms, MD — M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/4/67

23C. PHYSICIAN'S NAME (Type): Stephen Toms, M.D. M.D.

23D. ADDRESS: 1712 Winford Rd.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/7/67.	St. Johns Cemetery	Hydes, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 4 1967	Robert E. Farley M.D.	Leonard J. Ruck, Inc.	Balto. Md. 21214

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-431 BIRTH NO. 67 11574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11574

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM H. WILDBERGER

2. DATE AND HOUR OF DEATH: 12/3/67. 17:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital 35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21206 27-34
D. STREET ADDRESS (If rural, give location): 4002 Echodale Ave

5. SEX: M
6. RACE: W
7. MARRIED, ~~NEVER MARRIED, WIDOWED, DIVORCED (specify)~~: Married
8. DATE OF BIRTH: 6/17/04
9. AGE (In years last birthday): 63
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Draftsman
10B. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fred Wildberger
14. MOTHER'S MAIDEN NAME: Elizabeth Smith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-54-9341
17. INFORMANT: Mrs. Maude E. Wildberger
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cervical Spondylosis ? possible and compression
DUE TO
(B) Cirrhosis of the liver
DUE TO
(C) Diabetes mellitus
chronic alcoholism, Encephalitis

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/1 1967 to 12/3 1967, that (I) (we) last saw the deceased alive on 12/3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Francisco Baltazar, Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/3/67
23C. PHYSICIAN'S NAME (Type): FRANCISCO BALTAZAR, JR. M.D.
23D. ADDRESS: Church Home & Hosp. 100 N. Broadway

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/7/67.
24C. NAME of CEMETERY or CREMATORY: St. Johns Lutheran Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. P-613

M.E. CASE NO. 67 11575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. X 67 11575

1. NAME OF DECEASED (Type or Print): PROFFITT, MRS. MYRTLE S.

2. DATE AND HOUR OF DEATH: 12/3/67 - 2:25 PM. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL. 48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD B. COUNTY: BALTO. Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 7407 BRIGHTSIDE RD.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: March 20, 1893

9. AGE (In years last birthday): 74

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VA.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Albert ? HARVEY

14. MOTHER'S MAIDEN NAME: Alice MOORE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 213-34-3689

17. INFORMANT: Mr. Marvine W. Proffitt ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 715 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) SEPTIC SHOCK — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.

DUE TO

(B) SACRAL DECUBITUS. — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. SEVERE PARKINSON'S DISEASE

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/29 19 67 to 12/3 19 67, that (I) (we) last saw the deceased alive on 12/3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Nabil F. Warsal M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12/3/67

23C. PHYSICIAN'S NAME (Type): NABIL F. WARSAL M.D.

23D. ADDRESS: Maryland General Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/6/67.

24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

M-240

BIRTH NO. 67 11576

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11576

1. NAME OF DECEASED (Type or Print): JAMES H. MCCULLOH

2. DATE AND HOUR OF DEATH: 11-30 '67 | 2:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-06
D. STREET ADDRESS (If rural, give location): 1701 E. 30th. St

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 03-25 1885
9. AGE (In years last birthday): 82
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Bricklayer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Geo. McCulloh
14. MOTHER'S MAIDEN NAME: Mary Canoles

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-10-5304
17. INFORMANT: Mr. Richard N. McCulloh, ADDRESS: 3107 White Ave. #14

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. E904.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) BRONCHOPNEUMONIA, BILAT.
DUE TO
(B) SUBDURAL HEMATOMATA, BILATERAL, MASSIVE, OLD
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY CHIEF OR ASST. MEDICAL EXAMINER — M. D.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): X
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): UNKNOWN
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): UNKNOWN 00-00

21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour): UNKNOWN
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? PRESUMABLY FELL

22. I certify that (I) (this hospital) attended the deceased from 11-9 1967 to 11-30 1967, that (I) (we) last saw the deceased alive on 11-30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fridthjofur Bjornsson M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 11/30 67
23C. PHYSICIAN'S NAME (Type): F. BJORNSSON M.D.
23D. ADDRESS: Maryland General Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/4/67.
24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

N 834.2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

M-626 67 11577

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11577

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SIDNEY B. MERCER

2. DATE AND HOUR PRONOUNCED DEAD: December 1, 1967 3:07 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Johns Hopkins Hospital (DOA)

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2023 East Belvedere Ave ~~1950 E. Jopper Road~~

2738

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Jan. 28, 1906
9. AGE (In years last birthday): 61
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chef
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James B Mercer
14. MOTHER'S MAIDEN NAME: Molly Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WW 11
16. SOCIAL SECURITY NO.: 219-01-7353
17. INFORMANT: Mrs Marie Mercer ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection [X] Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: December 1, 1967

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12/4/67
23C. NAME of CEMETERY or CREMATORY: Moreland Memorial Pk
23D. LOCATION (City, town, or county) (State): Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
24B. NAME OF REGISTRAR: Robert E. Farber, M.D.
24C. FUNERAL DIRECTOR: Leonard J Ruck Inc. ADDRESS: 5305 Harford Rd

VS 151-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 7-623 67 11578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11578

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FRANCES C. FORREST

2. DATE AND HOUR OF DEATH: Nov 29, 1967, 7 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp. 44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21206 27-44
D. STREET ADDRESS (If rural, give location): 5916 WALTHER BLVD.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 12-24-1891
9. AGE (In years last birthday): 75
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: FRANK MARKERT
14. MOTHER'S MAIDEN NAME: MARY Kram

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Charles W. Forrest
ADDRESS: (Same)

MEDICAL CERTIFICATION

1B. 521.1

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Gastro Enteritis — ?
DUE TO
(B) Dehydration
DUE TO
(C) Shock

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Toxic hepatitis due to Enteritis Ill.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov 29 19 67 to Nov 29 19 67, that (I) (we) last saw the deceased alive on ____ 19 ____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Zoltan Zarday M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: Nov 29, 1967
23C. PHYSICIAN'S NAME (Type): ZOLTAN ZARDAY M.D.
23D. ADDRESS: Union Memorial Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/4/67.
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

45-73-95 ED 1

M-450

BIRTH NO. 67 11579

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11579

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Estelle Miller

2. DATE AND HOUR OF DEATH: 11-28-1967 / 30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Ave., Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 116½ Kinship Way # 21222 005

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 2/27/18
9. AGE (In years last birthday): 49
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10B. KIND OF BUSINESS OR INDUSTRY: Resteurant
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank (Unknown)
14. MOTHER'S MAIDEN NAME: Della Cross

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): — — — —
16. SOCIAL SECURITY NO.: 241-05-2429
17. INFORMANT: BCH: Records 4940 Eastern Ave. ADDRESS # 21224 Baltimore, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
18. 593 X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Azotemia
DUE TO
(B) Scleroderma + renal involvement
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 10-18 1967 to 11-28 1967, that (I) (we) last saw the deceased alive on 11-28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: P. Desmond M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 11-28-67.
23C. PHYSICIAN'S NAME (Type): P. Desmond M.D.
23D. ADDRESS: BALTIMORE CITY HOSPITALS 4940 Eastern Ave. Baltimore, Maryland #21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 1, 1967
24C. NAME of CEMETERY or CREMATORY: Beck"s Cemetery
24D. LOCATION (City, town, or county) (State): Lexington, North Carolina

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
25B. NAME OF REGISTRAR: Robert E. Stanley, M.D.
25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Inc. ADDRESS: Balto. Md. 21202

VS 150-REV. 1/1/65

1

B-660 67 11580

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11580

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROBERT BREWER

2. DATE AND HOUR PRONOUNCED DEAD: December 2, 1967 1:30 a m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-04
D. STREET ADDRESS (If rural, give location): 3604 10th St.

43/99

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	Aug 17.1911	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mgr	Grocery Store	N C	USA

13. FATHER'S NAME: D E Brewer

14. MOTHER'S MAIDEN NAME: Elizabeth Bruton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Family ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E981X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple gunshot wounds

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Food Market

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Giles Food Mkt. 913 Patapsco Ave.

21D. TIME OF INJURY (APPROX.): (Month) 12 (Day) 2 (Year) 67 (Hour) 1:00 a.m.

21E. INJURY OCCURRED: WHILE AT WORK [X] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR? Subject shot during holdup 25-52

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 2, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/7/67

23C. NAME of CEMETERY or CREMATORY: Thomasville, No. Carolina

23D. LOCATION (City, town, or county) (State): Thomasville, N.C.

24A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

24B. NAME OF REGISTRAR: Robert E. Faber, M.D.

24C. FUNERAL DIRECTOR: McCully F.H. 937 Patapsco Ave.

ADDRESS: 2/2/85

VS 151-REV. 1/1/65

N869.4

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-510 67 11581

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. X 67 11581

1. NAME OF DECEASED (Type or Print): SCHIMPF, FREDERICK J

2. DATE AND HOUR OF DEATH: 11/29/67 11:10P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: a.a.Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): PASADENA 21122 52-00
D. STREET ADDRESS (If rural, give location): 896 RIVERSIDE AVENUE

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 08/03/07
9. AGE (In years last birthday): 60 — If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LOAN SERVICE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: FREDERICK SCHIMPF
14. MOTHER'S MAIDEN NAME: ELLEN EICOFF

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-10-9374
17. INFORMANT: ST AGNES RECORDS - CATON & WILKENS AVE. ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 540.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCT — 4 hrs.
DUE TO
(B) HEMORRHAGIC GASTRITIS — 72 hrs.
DUE TO
(C) PEPTIC ULCER DISEASE — Years.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC BRONCHITIS, EMPHYSEMA — Years.

19A. DATE OF OPERATION: 11/27/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: GASTRIC HEMORRHAGE
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 27, 1967 to NOVEMBER 29, 1967, that (I) (we) last saw the deceased alive on NOVEMBER 29, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W E Signor M.D. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 11/29/67
23C. PHYSICIAN'S NAME (Type): W. E. SIGNOR M.D.
23D. ADDRESS: ST AGNES HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12-2-1967
24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Park
24D. LOCATION (City, town, or county) (State): Baltimore County, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
25B. NAME OF REGISTRAR: Robert E. Foster M.D.
25C. FUNERAL DIRECTOR: George J. Gonce, ADDRESS: 1001 Ritchie Hgwy., Baltimore

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-450

BIRTH NO. 67 11582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11582

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Julian Albert

2. DATE AND HOUR OF DEATH: Nov. 29 1967 | 6:40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 221 S. Robinson St.

1-02

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 10/3/01
9. AGE (In years last birthday): 66
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Car Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Automotive
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mike Julian
14. MOTHER'S MAIDEN NAME: Jennie Chester

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-10-1539
17. INFORMANT: Laura Julian
ADDRESS: 221 S. Robinson St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 11 Days
DUE TO
(B) Arteriosclerotic Cardiovascular Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11/28/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Heart block
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 18 1967 to Nov. 29 1967, that (I) (we) last saw the deceased alive on Nov. 29 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: N. Suarez M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 11/29/67
23C. PHYSICIAN'S NAME (Type): NENITA L. SUAREZ M.D.
23D. ADDRESS: Church Home & Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-2-67
24C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Nicholas T. Matthews
ADDRESS: 3021 Eastern Ave., Baltimore, Md.

VS 150-REV. 1/1/65

BIRTH NO. C-535 67 11583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11583

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM CURTIS CONDON

2. DATE AND HOUR OF DEATH: 28 Nov 67 | 11 30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIV. OF MD. HOS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD B. COUNTY: WASHINGTON Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): HAGERSTOWN 71-03

D. STREET ADDRESS (If rural, give location): 932 CHESTNUT

5. SEX: M

6. RACE: CAU

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 5/16/03

9. AGE (In years last birthday): 64

If Under 1 Yr. Months: Days: Hours: If Under 24 Hrs. Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FLAGMAN

10B. KIND OF BUSINESS OR INDUSTRY: R.R.

11. BIRTHPLACE (State or foreign country): ADAMS CO. ~~ARK~~ Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM J. CONDON

14. MOTHER'S MAIDEN NAME: NORA F. SEASE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO ~~UNK~~

(If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.: 214-09-5124

17. INFORMANT: MRS. ~~LILLIAN~~ V. CONDON

ADDRESS: 932 CHESTNUT STREET, HAGERSTOWN, MARYLAND.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 204.3 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: ACUTE LYMPHOCYTIC LEUKEMIA — INTERVAL BETWEEN ONSET AND DEATH: 9 Mos

(B) DUE TO: LEUKOPENIA — ? - 1 Month

(C): THROMBOCYTOPENIA — ? - 1 "

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-4- 1967 to 11-28 1967, that (I) (we) last saw the deceased alive on 11-28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stanley Music M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 11/28/67

23C. PHYSICIAN'S NAME (Type): STANLEY MUSIC M.D.

23D. ADDRESS: C/O UNIV. of Md. HOSP

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/1/67

24C. NAME of CEMETERY or CREMATORY: REST HAVEN CEMETERY

24D. LOCATION (City, town, or county) (State): HAGERSTOWN, WASH. CO. MARYLAND.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: CHARLES M. ROUZER

ADDRESS: HAGERSTOWN, MARYLAND.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

38

50-68-18 ED 1

J-525

BIRTH NO. 67 11584

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11584

1. NAME OF DECEASED (Type or Print): Johnson Lola B.

2. DATE AND HOUR OF DEATH: 12/1/67 1:30P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4940 Eastern Ave. Baltimore, Maryland # 21224

Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY: Baltimore Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Middle River 21200

D. STREET ADDRESS (If rural, give location): 8 Floral Place.

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 8/21/93

9. AGE (In years lost birthday): 74

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Tenn

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomason Alfred

14. MOTHER'S MAIDEN NAME: Aldersen, Laura

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 400 16 9961

17. INFORMANT: BCH: Records 4940 Eastern Ave. Baltimore, Md.

ADDRESS: #21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 8 hours

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/1/67 11am 19 to 12/1/67 1pm 19, that (I) (we) last saw the deceased alive on 12/1/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert N Hill M.D.

M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/1/67

23C. PHYSICIAN'S NAME (Type): Robert N Hill

M.O.

23D. ADDRESS: Baltimore City Hospitals 5948 E. Pratt, Baltimore Md

24A. BURIAL CREMATION, REMOVAL (Specify): Removal

24B. DATE: 12/3/67

24C. NAME of CEMETERY or CREMATORY: Wilkinson&Wiseman Funeral Home

24D. LOCATION (City, town, or county) (State): Portland, Tenn.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Bruzdzinski Funeral Home

ADDRESS: 1407 Eastern Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B-640 67 11585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11585

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HATTIE C. BURRELL

2. DATE AND HOUR OF DEATH: 1st DEC. 1967 | 8-10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 11-01

D. STREET ADDRESS (If rural, give location): 1301 SAINT PAUL ST.

5. SEX: F

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Separated

8. DATE OF BIRTH: 7-20-88

9. AGE (In years last birthday): 79

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Walter Meredith

14. MOTHER'S MAIDEN NAME: Mary Walters

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Janice Burrell

ADDRESS: 1301 St. Paul St.

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 443 X

(A) Cerebral Haemmorhage — 24 hours

DUE TO

(B)

DUE TO

(C) Hypertensive C.V.D — 2 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchial Asthma

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-30- 1967 to 12-1- 1967, that (I) (we) last saw the deceased alive on 12-1- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Zakaddin Vera M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-1-67

23C. PHYSICIAN'S NAME (Type): ZAKADDDIN VERA M.D.

23D. ADDRESS: Lutheran Hospital Balto 21216

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/5/67

24C. NAME of CEMETERY or CREMATORY: Mt. Olivet Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 4 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: JOHN F. DENNY, Inc.

ADDRESS: 715 Light St.

VS 150-REV. 1/1/65

1
R-420

67 11586 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11586

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RALPH G. ROWLES

2. DATE AND HOUR PRONOUNCED DEAD: December 3, 1967 7:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 2803 Eastshire Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-42
D. STREET ADDRESS (If rural, give location): 2803 Eastshire Drive

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 12 22 1891
9. AGE (In years last birthday): 76
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner
10B. KIND OF BUSINESS OR INDUSTRY: Coal
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: A. C. Rowles
14. MOTHER'S MAIDEN NAME: Lydia Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Family
ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 443 X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive and arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: December 4, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12 7 67
23C. NAME of CEMETERY or CREMATORY: Sunset
23D. LOCATION (City, town, or county) (State): Sophia, W. Va.

24A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
24B. NAME OF REGISTRAR: Robert E. Fahrney
24C. FUNERAL DIRECTOR: Mc Cully
ADDRESS: 237 Pat. Ave.

VS 151-REV. 1/1/65

1.
B-640

67 11587 BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11587

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CLARENCE BARLOW

2. DATE AND HOUR PRONOUNCED DEAD: December 3, 1967 | 5:30 a M.

CERTIFICATE AMENDED 3-18-68

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
00
923 Mayadon Ct. D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21225 25-04
D. STREET ADDRESS (If rural, give location): 923 Mayadon Ct.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	May 19, 1908	59				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter (Ret.)	Bichoff & Co.	West Virginia	U.S.A.

13. FATHER'S NAME: William Barlow

14. MOTHER'S MAIDEN NAME: Emily Booth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	Unknown	Mr. Kenneth R. Barlow (son)	4111 Orchard Ave. Balto. 25, Md.

MEDICAL CERTIFICATION

1B. E916.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) Carbon Monoxide Poisoning
3rd Degree 100% burns
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES	YES

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 923 Mayadon Ct. 25-04

21D. TIME OF INJURY (APPROX.): (Month) 12 (Day) 3 (Year) 67 (Hour) 3:50 am

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Subject in house fire

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 3, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/6/67	Glen Haven Memorial Park	Glen Burnie, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 5 1967	Robert E. Faulkner	E. C. Johnson Singleton Funeral Home	Glen Burnie, Md.

VS 151-REV. 1/1/65

N968.0

Letter from M.E.'s office 3-18-68 M.H.

W-352

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11588 Registered No. 67 11588

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Florence G. Whittington

2. DATE AND HOUR OF DEATH: Dec. 1, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 412 Hollen Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-12
D. STREET ADDRESS (If rural, give location): 412 Hollen Road

5. SEX: Female
6. RACE: Cau.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: June 28, 1889
9. AGE (In years last birthday): 78 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Walter Gellespie
14. MOTHER'S MAIDEN NAME: Annie Stone

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 387-09-3148 D
17. INFORMANT: Mrs. Robert Platt, ADDRESS: 6 Longwood Road

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I 153.3
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma recto-sigmoid — INTERVAL BETWEEN ONSET AND DEATH: 6 years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Oct. 31, 1961
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: above
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from October 1, 1961 19 to Dec. 1, 1967 19, that (I) (we) last saw the deceased alive on Nov. 29, 1967 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death. Dec. 4, 1967

23A. SIGNATURE: A. S. Chalfant M.D. Attending XX ~~Phys.~~ ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Dec. 4, 1967
23C. PHYSICIAN'S NAME (Type): A. S. Chalfant, M.D. M.D.
23D. ADDRESS: 6210 York Road

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/4/67
24C. NAME of CEMETERY or CREMATORY: Govans Presbyterian Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: C. Vernon Lemmon ADDRESS: 4611 Park Heights Ave.

VS 150-REV. 1/1/65

G-650

67 11589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11589

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GRIMM, HAZEL R

2. DATE AND HOUR OF DEATH: 12-4-67 | 12:12 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BON SECOURS HOSPITAL

34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: A.A.C.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): GAMBRILLS 52-00

D. STREET ADDRESS (If rural, give location): ROUTE 1 Box 72

5. SEX: Female

6. RACE: CAUC.

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 12-13-16

9. AGE (In years last birthday): 50

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: HARRY SHERMAN

14. MOTHER'S MAIDEN NAME: Upton, Ethel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): –

(If yes, give war or dates of service): –

16. SOCIAL SECURITY NO.: 212-14-8948

17. INFORMANT: John J. Grimm, same as 4

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. 416X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Heart Failure. — INTERVAL BETWEEN ONSET AND DEATH: 1 month

DUE TO

(B) Rheumatic heart disease — years

~~DUE TO~~

(C) Hepatic Failure — 10 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: – 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: –

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov 18 1967 to Dec 4 1967, that (I) (we) last saw the deceased alive on Dec 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Yong Cho M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-4-'67

23C. PHYSICIAN'S NAME (Type): YONG CHO M.D.

23D. ADDRESS: Bon Secours Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 7 Dec. 67

24C. NAME of CEMETERY or CREMATORY: Glen Haven Memorial Park

24D. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Kirkley Funeral Home, Glen Burnie, Md.

ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

43-50-39 1
ME

BIRTH NO. D-400 67 11590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. X 67 11590

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DILL, GERTRUDE MARGARET

2. DATE AND HOUR OF DEATH: 12/2/67 11 AM. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, Baltimore Maryland 21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 36 PELGZAR AVENUE 21221

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 7-17-16
9. AGE (In years last birthday): 51
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY: UNION TRUST CO
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH SEITZ
14. MOTHER'S MAIDEN NAME: MAGDALENE HAGAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNK
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-10-2478
17. INFORMANT: RECORDS: BALTIMORE CITY HOSPITALS
ADDRESS: 4940 EASTERN AVENUE BALTIMORE MARYLAND MD 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 527.2
(A) Chronic obstructive pulmonary disease — 7 years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YESS
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/27 1967 to 12/2 1967, that (I) (we) last saw the deceased alive on 12/2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Leonard Lippman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/2/67
23C. PHYSICIAN'S NAME (Type): LEONARD LIPPMAN M.D.
23D. ADDRESS: BALT. CITY HOSPITALS 4940 EASTERN AVE. BALTIMORE MARYLAND 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/5/67
24C. NAME of CEMETERY or CREMATORY: OAK LAWN
24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Fahey
25C. FUNERAL DIRECTOR: J.G. CONNELLY SONS
ADDRESS: 300 MACE

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-650

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11591

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CRUM, WILLIAM

2. DATE AND HOUR OF DEATH: 12-3-67 2:20A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE, 53-00
D. STREET ADDRESS (If rural, give location): 112 VICTORIA ROAD

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 7-27-13
9. AGE (In years lost birthday): 54
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FIREMAN
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: WILLIAM CRUM
14. MOTHER'S MAIDEN NAME: SARAH MURPHY
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNK
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ESTHER CRUM ADDRESS: ABOVE

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 162.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) SUPERIOR VENA CAVA SYNDROME — 4 WEEKS.

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) NEOPLASM - (BRONCHOGENIC CA.) — ?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from NOV 28 19 67 to DEC 3 19 67, that (I) (we) last saw the deceased alive on DEC 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jack S. Brandes M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/3/67
23C. PHYSICIAN'S NAME (Type): JACK S. BRANDES M.D.
23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/6/67
24C. NAME of CEMETERY or CREMATORY: HOLLY HILL CEM
24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: J.G. CONNELLY SONS ADDRESS: 300 MACE

VS 150-REV. 1/1/65

5-1231

C-462

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11592

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SR. M. SEBASTIAN RSM (CLARK)

2. DATE AND HOUR OF DEATH: 1 DEC 67 8 50 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
Stella Maris Hospice
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Towson, Md. Balto Co
D. STREET ADDRESS (If rural, give location): 53-00

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	NEVER MARRIED	6-2-98	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Religious	SISTER OF MERCY	Maryland	U.S.A.

13. FATHER'S NAME: John G. Clark

14. MOTHER'S MAIDEN NAME: ~~Mary~~ Lilly A. Knott

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 178 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) METASTATIC CARCINOMA to LUNG — INTERVAL BETWEEN ONSET AND DEATH: 3-4 yrs.

(B) DUE TO CARCINOMA of BREAST RIGHT about 4 yrs

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
1963	Ca of (R) BREAST	YES	NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 5 OCT 1967 to 1 DEC 1967, that ~~I~~ (we) last saw the deceased alive on 1 DEC 1967 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Salvatore R. Donohue M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1 DEC 67

23C. PHYSICIAN'S NAME (Type): SALVATORE R. DONOHUE M.D.

23D. ADDRESS: MERCY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	12/4/67	MT. ST. AGNES CONVENT	BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 5 1967	Robert E. Tankersley M.D.	H.W. MEARS & SON	805 N. CALVERT ST.

VS 150-REV. 1/1/65

R-306

67 11593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11593

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Thomas C. Reed

2. DATE AND HOUR OF DEATH 12-3-67 6:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hospital

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 20-01

D. STREET ADDRESS (If rural, give location) 310 N. Fulton Ave

5. SEX M

6. RACE N

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated

8. DATE OF BIRTH 8-31-27

9. AGE (In years last birthday) 40

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Thomas Reed

14. MOTHER'S MAIDEN NAME Helen Wilson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Yes

(If yes, give war or dates of service) ?

16. SOCIAL SECURITY NO. 212-22-1814

17. INFORMANT Patient

ADDRESS

MEDICAL CERTIFICATION

18. 591 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pulmonary edema

DUE TO uremia

~~Hypertensive Cardiovascular Disease~~

(B) DUE TO Glomerulonephritis

(C)

INTERVAL BETWEEN ONSET AND DEATH

approximately 2 years known

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, ~~factory~~, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-20 1967 to 12-3 1967, that (I) (we) last saw the deceased alive on 12-3 1967 and that in (my) (our) opinion death accurred an the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE William L. Boddie M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED 12-3-67

23C. PHYSICIAN'S NAME (Type) WILLIAM L. BODDIE M.D.

23D. ADDRESS Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL

24B. DATE 12-

24C. NAME of CEMETERY or CREMATORY BALTIMORE NAT. CEM.

24D. LOCATION (City, town, or county) (State) 5501 FREDERICK-BALTO. MD

25A. DATE REC'D BY HEALTH DEPT. DEC 5 1967

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR MARGARETTA B. BROWN

ADDRESS 3106 WALBROOK AVE.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-626

67 11594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11594

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Deares, Adam

2. DATE AND HOUR OF DEATH: 12-3-67 | 2:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): North Charles General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 21224

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-11

D. STREET ADDRESS (If rural, give location): 3207 O'Donnell St.

49

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: 9-13-1901

9. AGE (In years last birthday): 66

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10B. KIND OF BUSINESS OR INDUSTRY: Cloverland Dairy

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Deares, (Unknown)

14. MOTHER'S MAIDEN NAME: (Unknown)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-01-9126

17. INFORMANT: chart (North Chas. Gen. Hosp.) ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastasic Ca of the bladder.

DUE TO

(B) Stroke.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

181.0

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-21 1967 to 12-3 1967, that (I) (we) last saw the deceased alive on 12-3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Luis E. Rempel M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12-3-67

23C. PHYSICIAN'S NAME (Type): Benjamin Highstein M.D.

23D. ADDRESS: 121 South Highland Ave. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-6-67

24C. NAME of CEMETERY or CREMATORY: Oak Lawn

24D. LOCATION (City, town, or county) (State): Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967

25B. NAME OF REGISTRAR: Robert E. Staley, M.D.

25C. FUNERAL DIRECTOR: Thelma A. Hoffmann

ADDRESS: 3218 Hudson St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-6221

67 11595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11595

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Burgess Mr. William

2. DATE AND HOUR OF DEATH: 12-1-67 ; 00 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secour

34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto 26-11

D. STREET ADDRESS (If rural, give location): 6015 East Ave

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 10-29-96

9. AGE (In years last birthday): 71

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Police Dept

10B. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? America, USA.

13. FATHER'S NAME: Burgess

14. MOTHER'S MAIDEN NAME: Agnes

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Navy

(If yes, give war or dates of service): Merchant Marine

16. SOCIAL SECURITY NO.: 217-38-2389

17. INFORMANT: Daughter

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Thrombosis of abdominal aorta w. gangrene of rt. foot — INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO

(B) Arteriosclerosis, generalized — years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Adenocarcinoma of colon — wks.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from NOV 30 1967 to DEC 1 1967, that (I) (we) last saw the deceased alive on 12 30 PM DEC 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: DEC 1 '67

23C. PHYSICIAN'S NAME (Type): SOO WOONG HONG M.D.

23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-5-67

24C. NAME of CEMETERY or CREMATORY: Holy Rosary

24D. LOCATION (City, town, or county) (State): Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Foulkey M.D.

25C. FUNERAL DIRECTOR: Thelma A. Hoffmann

ADDRESS: 3218 Hudson

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-4121

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11596 Registered No. 67 11596

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Virginio. JAMES X. SELVAGGI

2. DATE AND HOUR OF DEATH 12/1/67 10 50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL, INC.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY: C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 8-01 D. STREET ADDRESS (If rural, give location): 2819 BRENDAN AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	M	8/5/1890	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED Foreman	Tailoring	ITALY	? U.S.A.

13. FATHER'S NAME: THOMAS SELVAGGI

14. MOTHER'S MAIDEN NAME: JULIA ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-05-8722A

17. INFORMANT: Margaret Pfister Selvaggi, wife, above — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 157X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CACHEXIA — INTERVAL BETWEEN ONSET AND DEATH: CHRONIC

DUE TO

(B) PROBABLE DIFFUSE CARCINOMATOSIS — "

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) PROBABLE Ca OF PANCREAS — "

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0 NONE		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/15/ 1967 to 12/1 1967, that (I) (we) last saw the deceased alive on 12/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: B. Ominsky M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12/1/67

23C. PHYSICIAN'S NAME (Type): BARRY OMINSKY M.D.

23D. ADDRESS: MERCY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/5/67	Holy Redeemer Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. DEC 5 1967

25B. NAME OF REGISTRAR Robert E. Talley, M.D.

25C. FUNERAL DIRECTOR — ADDRESS: Schimunek Funeral Home, Inc. 3331 Brehms Lane

VS 150-REV. 1/1/65

1
B-640

67 11597 BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11597

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HENRY A. BRILL JR.	2. DATE AND HOUR PRONOUNCED DEAD: December 2, 1967 | 8:50 a.m.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 3229 Lawnview ~~3209 Longview~~ Ave.	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 8-01 D. STREET ADDRESS (If rural, give location): 3229 Lawnview ~~3209 Longview~~ Ave.

00

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	married	8/9/1924	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver	Marketing Ser. Co.	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Brill	Hazel Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no	217-16-1378	Helen Green Brill, wife, above	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Arteriosclerotic Cardiovascular Disease	
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 2, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/5/67	Moreland Memorial Park	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 5 1967	Robert E. Falkenhan	Schimunek Funeral Home, Inc.	3331 Brehms Lane

VS 151-REV. 1/1/65

A-142

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 11598 **CERTIFICATE OF DEATH** Registered No. 67 11598

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Florence Genevieve Aviles

2. DATE AND HOUR OF DEATH: Dec. 4, 1967 | 2:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hospital, 3100 Wyman Pk. Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2622 Kentucky Avenue

8-01

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	Married	10/8/01	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Pa.	USA

13. FATHER'S NAME: William Powell

14. MOTHER'S MAIDEN NAME: Bridget Conrey or Conry

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Records- US PHS Hospital, Balto, Md. ADDRESS:

MEDICAL CERTIFICATION

18. 410 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary edema — Hours

DUE TO

(B) Mitral stensois — Years

DUE TO

(C) Rheumatic heart disease — Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		yes	yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I)/(this hospital) attended the deceased from Nov. 28 1967 to Dec. 4 1967, that (I)/(we) last saw the deceased alive on Dec. 4 1967 and that in (my)/(our) opinion death occurred on the date and hour and from the causes stated above. (I)/(We) (did)/(did not) view the body after death.

23A. SIGNATURE: Michael E. Pelczar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12/4/67

23C. PHYSICIAN'S NAME (Type): Michael E. Pelczar, SA Surgeon (R) M.D.

23D. ADDRESS: US PHS Hospital, Balto, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/6/67	Baltimore Nat. Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 5 1967	Robert E. Fisher M.D.	Schimunek Funeral Home, Inc.	3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

G-536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11599 Registered No. 67 11599

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): James C. Gentry

2. DATE AND HOUR OF DEATH: 12-1-67 | 3:00 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2421 Welbridge Drive. Balto. Md.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto. City.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, Maryland 27-07
D. STREET ADDRESS (If rural, give location): 2421 Welbridge Drive.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Jul 4 1884
9. AGE (In years last birthday): 83
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Donkey Engineer.
10B. KIND OF BUSINESS OR INDUSTRY: Mining
11. BIRTHPLACE (State or foreign country): N.Car.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert T. Gentry
14. MOTHER'S MAIDEN NAME: Indy Tranham

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 233 10 5079
17. INFORMANT: Mrs. James Gentry ADDRESS: Balto. Md. 2421 Welbridge Dr.

MEDICAL CERTIFICATION

18. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebral vascular accident — 1 days
DUE TO
(B) Arteriosclerotic Cardiovascular disease ?
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia — 3 days

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from January 1966 to December 1 1967, that (I) ~~(we)~~ last saw the deceased alive on December 1 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We) (did)~~ (did not) view the body after death.

23A. SIGNATURE: A. Allen Spier M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/1/67
23C. PHYSICIAN'S NAME (Type): A. Allen Spier M.D.
23D. ADDRESS: 1501 Pentridge Rd. Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Removal
24B. DATE: 12-2-67
24C. NAME of CEMETERY or CREMATORY: Sunset Mem. Park Cem.
24D. LOCATION (City, town, or county) (State): Beckley, W. Va.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Fankuna
25C. FUNERAL DIRECTOR: Wm. E. Johnson. ADDRESS: 8521 Loch Raven Blvd. 21204

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

5-520

67 11600

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11600

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): NELLIE SYNOWKA

2. DATE AND HOUR PRONOUNCED DEAD: November 30, 1967 11:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital (DOA)

43 79

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mc Kees Rock,
D. STREET ADDRESS (If rural, give location): 325 Fair Oak Street

V-35

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
Female	White	Married	8/2/1907	60	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Carnegie, Pa.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Winzinek	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No.		None	Theodore Synowka	Glen Burnie, Md.

MEDICAL CERTIFICATION

1B. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D.

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED November 30, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/5/67	Resurrection Cemetery	Moon Township Allegheny, Pennsylvania

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 5 1967	Robert E. Farley M.D.	Raymond C. Fink	Glen Burnie, Md.

VS 151-REV. 1/1/65

1967 0 0 1 6 2 8

50-67-74 1
ME

G-435

BIRTH NO. 67 11601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11601

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GOLDEN, PAUL SR

2. DATE AND HOUR OF DEATH: 11/30/67 5:45 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto C
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 30 Crafton Road 21221

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 10-16-04
9. AGE (In years lost birthday): 63
If Under 1 Yr. Months / Days / Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY: MARTIN CO
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaae
14. MOTHER'S MAIDEN NAME: Katherine

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNK
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 207-07-7016
17. INFORMANT: Records: BCH 4940 Eastern Avenue 21224 — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
1B. 420.1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute myocardial infarction — 5 hours
DUE TO
(B) ASCVD
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/30/67 2:25 PM 19 to 11/30/67 5:45 PM 19, that (I) (we) last saw the deceased alive on 11/30/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Leonard Leppman — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 11/30/67
23C. PHYSICIAN'S NAME (Type): LEONARD LEPPMAN M.D.
23D. ADDRESS: BALT. CITY HOSPITALS. 4940 Eastern Avenue Baltimore Maryland 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/4/67
24C. NAME of CEMETERY or CREMATORY: GARDENS OF FAITH
24D. LOCATION (City, town, or county) (State): BALTO, MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: J.G. CONNELLY SONS — ADDRESS: 300 MACE

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

I-526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11602

Registered No. 67 11602

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN L. INGRAM

2. DATE AND HOUR OF DEATH: DECEMBER 1, 1967 | 4:00 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SOUTH BALTIMORE GENERAL HOSPITAL 1213 LIGHT STREET BALTO., MD. 21230

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21230

D. STREET ADDRESS (If rural, give location): 1425 SOUTH HANOVER STREET

23-01

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 12/10/79

9. AGE (In years last birthday): 87

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: HARM INGRAM

14. MOTHER'S MAIDEN NAME: SARAH THOMAS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Mary M. Ingram

ADDRESS: 1425 S. Hanover St.

MEDICAL CERTIFICATION

18. 421.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pneumonia ~~Arteriosclerotic Cardiovascular Disease~~

DUE TO

(B) ASCVD Disease

DUE TO

(C) Aortic Stenosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 11-23 19 67 to 12-1 19 67, that (I) (~~we~~) last saw the deceased alive on 12-1 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Anthony C. Lewandowski M.D.

Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: DECEMBER 2, 1967

23C. PHYSICIAN'S NAME (Type): Anthony C. Lewandowski M.D.

23D. ADDRESS: 2E. Read St. ZONE 21202

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12 5 67

24C. NAME of CEMETERY or CREMATORY: Glen Haven

24D. LOCATION (City, town, or county) (State): Glen Burnie, A. A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Tarkington

25C. FUNERAL DIRECTOR: Mc Cully

ADDRESS: 130 E. Fort Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-1531

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11603

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MICHAEL PAPANTONAKIS

2. DATE AND HOUR OF DEATH: 11-30-67 | 4.30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL
33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: GREECE
B. COUNTY: V-71
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ATHENS
D. STREET ADDRESS (If rural, give location): 7-5

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 10-26-95
9. AGE (In years last birthday): 72
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Greece
12. CITIZEN OF WHAT COUNTRY? Greece

13. FATHER'S NAME: NICHOLAS PAPANTONAKIS
14. MOTHER'S MAIDEN NAME: ~~POULA~~ MARY YERAKIOS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 128-32-9563
17. INFORMANT: Nicholas PAPANTONAKIS
ADDRESS: 818 Umbra ST.

MEDICAL CERTIFICATION

18. 156.2 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Hepatorenal failure — 1 wk
DUE TO
(B) Metastatic Liver Carcinoma, primary site undetermined — 2 mo.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from November 16 19 67 to November 30 19 67, that (I) (we) last saw the deceased alive on November 25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Coy Freeman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 11/30/67
23C. PHYSICIAN'S NAME (Type): COY FREEMAN M.D.
23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-4-67
24C. NAME of CEMETERY or CREMATORY: Greek Orthodox Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Faukman
25C. FUNERAL DIRECTOR: Nicholas T. Matthews
ADDRESS: 3021 Eastern Ave, Baltimore, Md.

VS 150-REV. 1/1/65

K-230

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11604

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11604

1. NAME OF DECEASED (Type or Print): KIGHT, JOSEPH L.

2. DATE AND HOUR OF DEATH: DECEMBER 1, 1967 11:43A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Balto Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 1317 BIRCH AVE. 21227

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 10/03/91

9. AGE (In years last birthday): 76

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY: B & O RR

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES~~XXXXX~~ KIGHT

14. MOTHER'S MAIDEN NAME: SARAH DANIELS KIGHT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.:

17. INFORMANT: ST. AGNES HOSPITAL RECORDS ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Disseminated Metastatic DUE TO

(B) Bronchogenic - Ca. DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

162.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 6

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 29 19 67 to DECEMBER 1 19 67, that (I) (we) last saw the deceased alive on DECEMBER 1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alejandro Mejia M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X

23B. DATE SIGNED: ~~XXXXXXXX~~ 12-1-67

23C. PHYSICIAN'S NAME (Type): ALEJANDRO MEJIA M.D.

23D. ADDRESS: St Agnes Hospital.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/4/67

24C. NAME of CEMETERY or CREMATORY: JENNINGS CHAPEL

24D. LOCATION (City, town, or county) (State): HOWARD CO. MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Fankuna

25C. FUNERAL DIRECTOR: E. S. MACNABB ADDRESS: 301 FREDERICK RD. 21228

VS 150-REV. 1/1/65

C-500

67 11605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11605

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Isaac J. Cohen

2. DATE AND HOUR OF DEATH: NOVEMBER 28/67/12 30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4003 Fernhill Ave

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-10

D. STREET ADDRESS (If rural, give location): 4003 Fernhill Ave

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Sept 17, 1880

9. AGE (In years last birthday): 87

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor

10B. KIND OF BUSINESS OR INDUSTRY: Air conditioning & Heating

11. BIRTHPLACE (State or foreign country): Lithuania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hillel Cohen

14. MOTHER'S MAIDEN NAME: Toba ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Zara Cohen ADDRESS 4003 Fernhill Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Arteriosclerotic cardiovasc disease and — INTERVAL BETWEEN ONSET AND DEATH: 10 yr.

DUE TO

(B)

DUE TO

(C) Nephrosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from May 31, 1967 to November 28 1967, that (I) (~~we~~) last saw the deceased alive on Nov. 28 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Morton M Krieger M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Nov. 29, 1967

23C. PHYSICIAN'S NAME (Type): MORTON KRIEGER M.D.

23D. ADDRESS: 615 HAMMONDS LANE 21225

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12-1-67

24C. NAME of CEMETERY or CREMATORY: CHIZUK AMUNO

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Tankersley

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., ADDRESS 6010 REISTERSTOWN RD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

BIRTH NO. G-431 67 11606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11606

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GERTRUDE GOLDBERG

2. DATE AND HOUR OF DEATH: DECEMBER 2, 1967 | 1:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3009 ROSALIND AVENUE

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-16

D. STREET ADDRESS (If rural, give location): 3009 Rosalind Avenue #21215

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	WIDOW		85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	AT HOME	RUSSIA	U.S.A

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-20-5158D

17. INFORMANT: Mr. ISIDOR SNYDER, ADDRESS: 5043 CHALGROVE AVE. #21215

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 + 260X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — 1 hour

DUE TO

(B) Coronary arteriosclerotic cardiovascular disease — unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus — unknown

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from June 22 1964 to Dec. 2, 1967, that (I) (~~we~~) last saw the deceased alive on Nov. 14 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Abraham B. Hurwitz M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Dec. 2, 1967

23C. PHYSICIAN'S NAME (Type): ABRAHAM B. HURWITZ M.D.

23D. ADDRESS: 7501 LIBERTY ROAD

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	12-3-67	BNAI ISRAEL	BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., ADDRESS: 6010 REISTERSTOWN RD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

BIRTH NO. L-152

M.E. CASE NO. 67 11607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11607

1. NAME OF DECEASED (Type or Print): MEYER LEVINSOHN

2. DATE AND HOUR OF DEATH: DECEMBER 2, 1967 | 8:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(If not in hospital or institution, give street address or location): 3637 Glengyle Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Balto Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 6813 Cherokee Drive

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: April 26, 1899

9. AGE (In years last birthday): 68

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10B. KIND OF BUSINESS OR INDUSTRY: Wholesale

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Levinsohn

14. MOTHER'S MAIDEN NAME: Rebecca ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES

(If yes, give war or dates of service): ARMY W.W. II

16. SOCIAL SECURITY NO.: 216-16-8381

17. INFORMANT: Mrs. Norma C. Lutins

ADDRESS: 6813 Cherokee Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
420.1	(A) Acute Myocardial Infarction	Sudden
	DUE TO Coronary Atherosclerosis	
	(B) Angina pectoris	7 years
	DUE TO Cardiac enlargement	10 years
	(C) Post rheumatic valvular heart disease	-

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1955 19 to Dec 2 1967, that (I) (~~we~~) last saw the deceased alive on Sept 13 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Louis P. Hamburger Jr. M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-3-67

23C. PHYSICIAN'S NAME (Type): Dr. Louis P. Hamburger Jr. M.D.

23D. ADDRESS: 1001 St. Paul Street

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-4-67

24C. NAME of CEMETERY or CREMATORY: Bnai Israel

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Tankey M.D.

25C. FUNERAL DIRECTOR: Sol Levinson & Bros.

ADDRESS: 6010 Reisterstown Road.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

1
C-142

67 11608 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11608

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARGARET CAPLES

2. DATE AND HOUR PRONOUNCED DEAD: December 1, 1967 11:02 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED 12-5-67

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 2601 Kirk Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give town): Baltimore

9-07

D. STREET ADDRESS (If rural, give location): 2601 Kirk Avenue

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced

8. DATE OF BIRTH: Feb. 28, ~~1967~~ 1902

9. AGE (In years last birthday): 65

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10B. KIND OF BUSINESS OR INDUSTRY: Drug Store

11. BIRTHPLACE (State or foreign country): Mt. Washington, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Scharon

14. MOTHER'S MAIDEN NAME: Sophia (Sadie) Scholl

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 219-30-3164

17. INFORMANT: Alfred W. Caples, Jr.

ADDRESS: 874 West End Ave. N.Y., N.Y. 10025

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I

420.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: December 1, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12-5-1967

23C. NAME of CEMETERY or CREMATORY: Druid Ridge Cem.

23D. LOCATION (City, town, or county) (State): Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

24B. NAME OF REGISTRAR: Robert E. Falkner

24C. FUNERAL DIRECTOR: Wm. Cook-Brooks, Inc.

ADDRESS: Balto., Md.

VS 151-REV. 1/1/65

V.S. 153 and B.C. from Md. State
12-5-67 M.H.

1
B-632

67 11609

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11609

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): J. JAMES BROADDUS

2. DATE AND HOUR PRONOUNCED DEAD: December 2, 1967 1:00 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 2828 W. Mulberry St. D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: 20-02

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 2828 W. Mulberry St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored		Jan.14th.04	63				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chauffuer	Construction	Virginia	U.S.A.

13. FATHER'S NAME: Unkown

14. MOTHER'S MAIDEN NAME: Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 219-05-5329

17. INFORMANT: Frances Broaddus

ADDRESS: Same

MEDICAL CERTIFICATION

1B. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 2, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/6/67	Arbutus Mem.Park Cem.	Arbutus Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 5 1967	Robert E. Fankyna	Stetson D.Wilson	1913 W.Balto.St

VS 151-REV. 1/1/65

H-200

67 11610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11610

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HOUCK, CATHERINE W.

2. DATE AND HOUR OF DEATH: DECEMBER 2, 1967 7:25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: ST. AGNES HOSPITAL

(If not in hospital or institution, give street address or location): WILKENS & CATON AVES. BALTIMORE, MD. 21229

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 21228 Balt. Co

C. CITY OR TOWN (If outside city limits, write RURAL or township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 1 SO. PARADISE AVENUE

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 03-23-91

9. AGE (In years last birthday): 76

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES Wolfe DEC'D

14. MOTHER'S MAIDEN NAME: ANNIE (SCHARF) DEC'D

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: J Floyd WILKINSON ADDRESS: WILKENS & CATON AVES ST. AGNES RECORDS BALTIMORE, MD. 21229

MEDICAL CERTIFICATION

CAUSE OF DEATH 4622 Wilmslow Rd 21210

INTERVAL BETWEEN ONSET AND DEATH

18. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL COMA

DUE TO

(B) C.V.A.

DUE TO

(C) A.S.C.V.D.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 22, 1967 to DECEMBER 2, 1967, that (X) (we) last saw the deceased alive on DECEMBER 2, 1967 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.

23A. SIGNATURE: Alejandro Mejia M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12-2-67.

23C. PHYSICIAN'S NAME (Type): ALEJANDRO MEJIA MD. M.D.

23D. ADDRESS: WILKENS & CATON AVE ST. AGNES HOSPITAL-BALTIMORE, MD. 21229

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-5-67

24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: R. Lee E. Fordyce

25C. FUNERAL DIRECTOR: Ellsworth Armacost ADDRESS: 4600 Liberty Hghts

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-6513

67 11611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11611

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN CARMODY

2. DATE AND HOUR OF DEATH: 11/30/67 9:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL OF BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-15

D. STREET ADDRESS (If rural, give location): 5975 Pimlico Road

5. SEX: Male

6. RACE: CAUCASIAN

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: Jan. 19, 1898

9. AGE (In years last birthday): 69

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Md. Racing Assoc. Mutual Dept.

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): San Francisco, Cal.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John A. Carmody

14. MOTHER'S MAIDEN NAME: Anna Kean

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Eva D. Carmody

ADDRESS: 5975 Pimlico Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure

DUE TO

(B) ASCVD

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): (2)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 11/16/67 19 to 11/30 19 67, that (I) (we) last saw the deceased alive on 11/30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Abe Levy M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 11/30/67

23C. PHYSICIAN'S NAME (Type): ABE LEVY M.D.

23D. ADDRESS: Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-4-67

24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Tankey M.D.

25C. FUNERAL DIRECTOR: Ellsworth Armacost

ADDRESS: 4600 Liberty Hghts. Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-5311

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11612

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11612

1. NAME OF DECEASED (Type or Print): CENTOFANTI, CESARINA

2. DATE AND HOUR OF DEATH: 12·3·67 | 9.15 p.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: HOUSE. B. COUNTY: Balto. Md.
C. CITY OR TOWN: Balto. (If outside city limits, write RURAL and give township) 28-41
D. STREET ADDRESS (If rural, give location): 3611 Howard. Pk. Ave.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never Married
8. DATE OF BIRTH: 10.21.87
9. AGE (In years last birthday): 80
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Argentine
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Raymond Centofanti
14. MOTHER'S MAIDEN NAME: Schmitt

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Yes
17. INFORMANT: Fred C Centofanti — Same
ADDRESS:

MEDICAL CERTIFICATION

18. 237 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Tumor of spinal cord — 11.14.67
DUE TO
(B) — 12·3·67
DUE TO
(C) Bronchopneumonia

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11·14·67 19 67 to 12·3·67 19 , that (I) (we) last saw the deceased alive on 12·3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Enrique Rafel M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12·3·67
23C. PHYSICIAN'S NAME (Type): ENRIQUE RAFEL M.D.
23D. ADDRESS: LUTHERAN HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12-7-67
24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Elsworth Armacost
ADDRESS: 4600 Lib Hghts

VS 150-REV. 1/1/65

B 420

BIRTH NO. 67 11613

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11613

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Wilson J. Black Sr.

2. DATE AND HOUR OF DEATH: November 28, 1967 | 3 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 3014 Belmont Avenue Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 1607
D. STREET ADDRESS (If rural, give location): 3014 Belmont Avenue

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Oct. 5, 1911
9. AGE (In years last birthday): 56
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charlie Black
14. MOTHER'S MAIDEN NAME: Ella Thompson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Harnetha Black
ADDRESS: 3014 Belmont Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 443 X

(A) Hypertensive Heart Disease
DUE TO
(B) Essential Hypertension
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/30 19 61 to 11/28 19 67, that (I) (we) last saw the deceased alive on 11/21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Emerson R. Julian M.D. Attending Phys. X Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/1/67
23C. PHYSICIAN'S NAME (Type): Emerson R. Julian, M.D.
23D. ADDRESS: 2329 Arunah Avenue Balto., Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-2-67
24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Pk.
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Arlington S. Phillips
ADDRESS: 1727 N. Monroe St

VS 150-REV. 1/1/65

1
S-600

67 11614 BALTIMORE CITY HEALTH DEPARTMENT 67 11614

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ELSIE M. SAWYER

2. DATE AND HOUR PRONOUNCED DEAD November 26, 1967 12:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

R 11-36 Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 19-02

D. STREET ADDRESS (If rural, give location) 1634 W. Fayette Street

5. SEX Female

6. RACE Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married

8. DATE OF BIRTH 8-27-17

9. AGE (In years last birthday) 50

If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Jefferson

14. MOTHER'S MAIDEN NAME Susie Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Paul R. Sawyer ADDRESS Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 581.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fatty metamorphosis of liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D.

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED November 26, 1967

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 11/30/67

23C. NAME of CEMETERY or CREMATORY Baltimore National

23D. LOCATION (City, town, or county) (State) Baltimore Md

24A. DATE REC'D BY HEALTH DEPT. DEC 5 1967

24B. NAME OF REGISTRAR Robert E. Farkuna

24C. FUNERAL DIRECTOR Arlington S. Phillips ADDRESS 5221 N. Monroe St.

VS 151-REV. 1/1/65

1
B-424

67 11615 BALTIMORE CITY HEALTH DEPARTMENT 67 11615

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ARTHUR L. BLACKWELL

2. DATE AND HOUR PRONOUNCED DEAD: November 26, 1967 7:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 811 Edmondson Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 811 Edmondson Avenue

17-03

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Divorced

8. DATE OF BIRTH: 11-10-1921

9. AGE (In years last birthday): 46

If Under 1 Yr. Months Days Hours Min. / If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lawrence Harden

14. MOTHER'S MAIDEN NAME: Frances Blackwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Yes

16. SOCIAL SECURITY NO.: 224-52-7591

17. INFORMANT: Mrs. Frances Bee

ADDRESS: 521 N. Gilmore St.

MEDICAL CERTIFICATION

1B. 581.0

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fatty Alteration of Liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): ~~XXXXX~~ home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 11/27/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12-1-67

23C. NAME of CEMETERY or CREMATORY: Baltimore National Cem.

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

24B. NAME OF REGISTRAR: Robert E. Farkas

24C. FUNERAL DIRECTOR: Arlington S. Phillips

ADDRESS: 1727 N. Monroe St.

VS 151-REV. 1/1/65

1
5-361

67 11616 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11616

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM Stanley SATTERFIELD

2. DATE AND HOUR PRONOUNCED DEAD: November 27, 1967 M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 928 N. Carrollton Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-01
D. STREET ADDRESS (If rural, give location): 928 N. Carrollton Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Married	7-13-1944	23				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Virginia	

13. FATHER'S NAME: John Satterfield

14. MOTHER'S MAIDEN NAME: Henrietta Lee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-40-2935

17. INFORMANT: John Satterfield ADDRESS: Same

MEDICAL CERTIFICATION

1B. 323X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — (A) DUE TO: Overdose of Narcotics

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO:

(C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

DATE SIGNED: 11/28/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12-1-67	Carver Mem. Pk.	Laurel Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 6 1967	Robert E. Farley, M.D.	Arlington A. Phillips	1727 N. Monroe St.

VS 151-REV. 1/1/65

1
J-525

67 11617 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11617

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GEORGE D. JENKINS

2. DATE AND HOUR PRONOUNCED DEAD: December 2, 1967 | 10:05 M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-02
D. STREET ADDRESS (If rural, give location): 4701 ~~4781~~ Parkside Gardenway Apt. B

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: 4/10/1898
9. AGE (In years last birthday): 69
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffer
10B. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James W. Jenkins
14. MOTHER'S MAIDEN NAME: Mollie Beane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: yes
17. INFORMANT: Mr. Thomas Jenkins
ADDRESS: 15 N. Decker Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 4221

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.
EXAMINER'S NAME (Type): Edward F. Wilson, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: December 3, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12/6/'67
23C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery
23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
24B. NAME OF REGISTRAR: Robert E. Farkas M.D.
24C. FUNERAL DIRECTOR: John A. Moran, Inc.
ADDRESS: 3000 E. Baltimore St

VS 151-REV. 1/1/65

1
F-655

67 11618 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11618

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GEORGE FERNING

2. DATE AND HOUR PRONOUNCED DEAD: December 2, 1967 | 7:37 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED 12-6-67

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 33/99 Johns Hopkins Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-05

D. STREET ADDRESS (If rural, give location): 2233 E. Pratt St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	10/4/'09	58				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Guard		Baltimore, Maryland	USA

13. FATHER'S NAME: Bernard Ferning

14. MOTHER'S MAIDEN NAME: Katherine Kraus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-05-2324

17. INFORMANT: Mrs. Marie K. Ferning ADDRESS: 2233 E. Pratt St

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 422.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes ✓ ~~No~~	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ ~~Inspection~~ X Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes X Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER X
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: December 3, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/6/'67	Sacred Heart Of Jesus Cemetery	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 5 1967	Robert E. Fitzgerald	John A. Moran, Inc.	3000 E. Baltimore St

VS 151-REV. 1/1/65

Letter from M.E.'s office 12-6-67 M.H.

L-2001

67 11619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

67 11619

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Florence A. Lewis

2. DATE AND HOUR OF DEATH: November 30, 1967 | 10 P.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 2567 Greenmount Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-08

D. STREET ADDRESS (If rural, give location): 2567 Greenmount Avenue

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: Feb. 26, 1880

9. AGE (In years last birthday): 87

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tavern Owner

10B. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George MacDonald

14. MOTHER'S MAIDEN NAME: Marie Schell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Clara Clyde

ADDRESS: 2567 Greenmount Ave.

MEDICAL CERTIFICATION

18. 450.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1964 19 to November 19 67, that (I) (~~we~~) last saw the deceased alive on November 25 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Loy M. Zimmerman M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/2/67

23C. PHYSICIAN'S NAME (Type): Loy M. Zimmerman M.D.

23D. ADDRESS: 3202 Harford Rd, Baltimore, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/4/67

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county): Baltimore (State): Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: John A. Moran, Inc.

ADDRESS: 3000 E. Balto. St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

G-536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO. 67 11620

Registered No. 67 11620

1. NAME OF DECEASED (Type or Print): Gentry, James

2. DATE AND HOUR OF DEATH: 12-1-67 | 9 05 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Bolton Hill Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 905 Mc Donough St. Mc Donough

7-04

5. SEX: M

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widower

8. DATE OF BIRTH: 5-4-96

9. AGE (In years lost birthday): 71

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10B. KIND OF BUSINESS OR INDUSTRY: J S Young Co

11. BIRTHPLACE (State or foreign country): Roxboro N.C.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: George Gentry

14. MOTHER'S MAIDEN NAME: Berta ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-09-0676

17. INFORMANT: Bolton Hill Nursing Home

ADDRESS: 1400 John St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
1	777X	
(A) DUE TO	CA / prostatectomy retention	1 year
(B) DUE TO	arteriosclerosis	years
(C)		

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/20 1967 to 12/1 1967, that (I) (we) last saw the deceased alive on 12/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/2/67

23C. PHYSICIAN'S NAME (Type): Allan H. Macht M.D.

23D. ADDRESS: 2 East Read St 21202

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/6/67

24C. NAME of CEMETERY or CREMATORY: Balto. National Cem

24D. LOCATION (City, town, or county) (State): 5501 Frederick Ave.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Joseph T. Eichenlaub

ADDRESS: 1129 N. Carlton St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

50-68-21 1
IW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H620

BIRTH NO. 67-23908 67 11621

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11621

1. NAME OF DECEASED (Type or Print): ~~Antionette~~ Baby Boy/ Harris

2. DATE AND HOUR OF DEATH: 12-1-67 8:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4940 Eastern Ave., Balto. Md. 21224
Baltimore City Hospitals
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2003 Guilford Avenue - 21218
12-04

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never Married
8. DATE OF BIRTH: 12-1-67
9. AGE (In years lost birthday): ~~[illegible]~~ If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 8 Min.: 23
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Antoinette Harris
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS: Baltimore City Hospitals
ADDRESS: 4940 Eastern Avenue, Baltimore, Md. 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I 773.51

(A) Respiratory Distress — 7 hrs 30 min
DUE TO
(B) Prematurity
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12:00 p.m. 12-1 19 67 to 8:30 p.m. 12-1 19 67, that (I) (we) last saw the deceased alive on 12-1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: D. V. Edwards M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-1-67
23C. PHYSICIAN'S NAME (Type): DALE VIRGINIA EDWARDS M.D.
Dale Virginia Edwards
23D. ADDRESS: BALTIMORE CITY HOSPITALS, 4940 Eastern Ave. 21224
1620 McElderry St., Balto. Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 6/67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cemetery
24D. LOCATION (City, town, or county) (State): Westport Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Milton E. Erickson
ADDRESS: 1129 N. Carlton St

VS 150-REV. 1/1/65

C-636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67-24163 67 11622 Registered No. 67 11622

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BABY GIRL CARTER

2. DATE AND HOUR OF DEATH: DEC. 2 1967 8:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 10-02

D. STREET ADDRESS (If rural, give location): 938 Abbott Ct.

5. SEX: F

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: Dec 2 1967

9. AGE (In years last birthday): 5 hrs.

If Under 1 Yr. Months: Days: Hours: 5 Min.: If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: Thelma Carter

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Thelma Carter ADDRESS: 938 Abbott Ct.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Pulmonary Hyaline Membrane — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Immaturity — 29 weeks

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): O

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 2 1967 to Dec 2 1967, that (I) (we) last saw the deceased alive on Dec 2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Norma Penaflor M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Dec 2, 67

23C. PHYSICIAN'S NAME (Type): NORMA PENAFLOR M.D.

23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Dec 5/67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem.

24D. LOCATION (City, town, or county) (State): Westport Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Milton E. Eliason ADDRESS: 1129 N. Carrollton

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

D-250

67 11623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11623

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES DIXON JR.

2. DATE AND HOUR OF DEATH: Dec 1, 1967 | 5⁰⁷ A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 9-08

D. STREET ADDRESS (If rural, give location): 816 EAST NORTH AVENUE 21202

5. SEX: MALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED

8. DATE OF BIRTH: 12-5-51

9. AGE (In years last birthday): 15

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JAMES DIXON

14. MOTHER'S MAIDEN NAME: LUCELLE MATHIS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Lucille Dixon

ADDRESS: 816 E. North Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 581.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage from Esophageal Varices — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Subarachnoid Bleeding — 12 hrs

DUE TO

(C) Chronic Active Hepatitis, Post-Necrotic Cirrhosis — 1½ years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Nov 16 1967 to Dec 1 1967, that (I) (~~we~~) last saw the deceased alive on 5 AM Dec 1 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Stephen H. Polman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: Dec 1, 1967

23C. PHYSICIAN'S NAME (Type): STEPHEN H. POLMAR M.D.

23D. ADDRESS: JOHNS HOPKINS HOSPITAL, BALT. 21205

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Dec 6/67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cemetery

24D. LOCATION (City, town, or county) (State): Westport Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Milton E. Eliason

ADDRESS: 1129 N. Carlton St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-615

BIRTH NO. 67 11624

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11624

1. NAME OF DECEASED (Type or Print): CORBIN, William

2. DATE AND HOUR OF DEATH: 12-2-67 7:05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 UNION MEMORIAL HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 12-03

D. STREET ADDRESS (If rural, give location): 2422 GUILFORD AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	N	widower	1-15-05	62				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CRANE OPERATOR	WESTINGHOUSE	VA.	U.S.A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): ? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ?

17. INFORMANT (SISTER): MARIE REESE ADDRESS: 2422 Guilford AVE.

MEDICAL CERTIFICATION

18. 150X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Ca of Esophagus — INTERVAL BETWEEN ONSET AND DEATH: ~12 months

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-1-67 19 to 12-2-67 19, that (I) (we) last saw the deceased alive on 12-2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Frank Palmisano M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-2-67

23C. PHYSICIAN'S NAME (Type): DR. FRANK S. PALMISANO M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/7/67

24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cem.

24D. LOCATION (City, town, or county) (State): A.A. County Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Falkenhan

25C. FUNERAL DIRECTOR: Gerald F. Eleckson ADDRESS: 1129 N. Carlton St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

1

K-523 67 11625

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11625

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (THESSALONIANA) Thessa L. KNIGHT

2. DATE AND HOUR PRONOUNCED DEAD: December 1, 1967 | 2:00 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Mercy Hospital D.O.A.

37/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. ~~COUNTY~~
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1504 Bethel St.

8-06

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored	Married	Dec 15, 1927	40				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Seaman		New Port News Va.	

13. FATHER'S NAME: Herbert Knight

14. MOTHER'S MAIDEN NAME: Daisy Wilkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No.

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Ernestine Knight ADDRESS: 1504 N. Bethel St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

422.1

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	YES

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE OF EXAMINER: Edward F. Wilson M.D.

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 2, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	Dec 1/67	Mt Calvary Cem	A.A. County Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 5 1967	Robert E. Farley M.D.	Gault, Eckhardt	1124 N. Carrollsq

VS 151-REV. 1/1/65

T-6501

BIRTH NO. 67 11626

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11626

1. NAME OF DECEASED (Type or Print): BEATRICE N. THORN

2. DATE AND HOUR OF DEATH: 12-3-67 | 9:15 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 MARYLAND GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: A.A.C.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): GLEN BURNIE 52-00
D. STREET ADDRESS (If rural, give location): 5 RIDGELY ROAD

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 4-28-29
9. AGE (In years last birthday): 38
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRED HELMS
14. MOTHER'S MAIDEN NAME: MANILA SHOEMAKER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: ELMER THORN — ADDRESS: AS ABOVE

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 175.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: — 12 years

(B) DUE TO: multiples metastases

(C) Ovarian carcinoma

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/7 1967 to 12/3 1967, that (I) (we) last saw the deceased alive on 12/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Nabil F. Wirsal M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/3/67
23C. PHYSICIAN'S NAME (Type): NABIL F. WIRSAL M.D.
23D. ADDRESS: Maryland Gen. Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 6 Dec. 67
24C. NAME of CEMETERY or CREMATORY: Glen Haven Memorial Park
24D. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Hirsley Funeral Home
ADDRESS: Glen Burnie

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

C-600

67 11627

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 11627

BIRTH NO.

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): URSULA CAREY

2. DATE AND HOUR PRONOUNCED DEAD: December 1, 1967 8:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1019 N. Arlington Street

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

16-01

D. STREET ADDRESS (If rural, give location): 1019 N. Arlington ~~Street~~ AVE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Negro	S	2/3/41	26				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Hamilton, virginia

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Wilbur Romey

14. MOTHER'S MAIDEN NAME: Imogene Carey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Ursula Young, 122 Oates St, Washington D C

MEDICAL CERTIFICATION

18. 286.5

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Severe malnutrition

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

DATE SIGNED: December 1, 1967

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/6/67

23C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetry

23D. LOCATION (City, town, or county) (State): A A County Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

24B. NAME OF REGISTRAR: Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR: A Halstead

ADDRESS: 1206 W North Ave

VS 151-REV. 1/1/65

1

S-512

67 11628

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 11628

BIRTH NO.

M.E. CASE NO.

Registered No.

1. NAME OF DECEASED (Type or Print): ALICE L. SAMPSON

2. DATE AND HOUR PRONOUNCED DEAD: December 3, 1967 | 10:00 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 4800 block of Old York Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-10

D. STREET ADDRESS (If rural, give location): 726 McCabe ~~St.~~ Ave

5. SEX: Female

6. RACE: Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): S

8. DATE OF BIRTH: 9/5/32

9. AGE (In years last birthday): 35

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Sylvester Royal

14. MOTHER'S MAIDEN NAME: Pauline Sampson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: M s Pauline Williams

ADDRESS: 2602 Garret Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E 891.5

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia

DUE TO Carbon Monoxide Poisoning

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 4800 block Old York Rd. 27-11

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12 2-3 67 ? m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Subject found in car, Parked

22. I certify that I held an Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 3, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/6/67

23C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cemetery

23D. LOCATION (City, town, or county) (State): A A Countyb Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: A Halstead

ADDRESS: 1206 W North Ave

VS 151-REV. 1/1/65

N 968.0

C-4621

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11629

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11629

1. NAME OF DECEASED (Type or Print): LULA CLARK

2. DATE AND HOUR OF DEATH: DECEMBER 2, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2107 Bryant Ave

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY: 15-04

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 2107 Bryant Ave

5. SEX: F

6. RACE: C

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): W

8. DATE OF BIRTH: 8/22/06

9. AGE (In years last birthday): 61

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James W Fields

14. MOTHER'S MAIDEN NAME: Nettie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 271-20-0261

17. INFORMANT: Mrs LaBoo ADDRESS: 1731 Linden Ave

MEDICAL CERTIFICATION

1B. 163X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Carcinoma of lungs

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/13 1967 to 12/2 1967, that (I) (we) last saw the deceased alive on 11/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A. C. Burwell M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/4/67

23C. PHYSICIAN'S NAME (Type): A. C. Burwell, M. D. M.D.

23D. ADDRESS: 1924 W. North Avenue Baltimore, MD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/6/67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem Park

24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Parker, M.D.

25C. FUNERAL DIRECTOR: Adolphus Halstead ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

37-63-42 LB 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M-253 67 11630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11630

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Nicholas Mezzanotti

2. DATE AND HOUR OF DEATH: 12-3-67 18 30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 2-01
D. STREET ADDRESS (If rural, give location): 2017 E. PRATT STREET 21231

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 7-30-25
9. AGE (In years last birthday): 42
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lineman
10B. KIND OF BUSINESS OR INDUSTRY: Water Front
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: DOMINIC MEZZANOTTI
14. MOTHER'S MAIDEN NAME: MARY DISAIA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): ———
16. SOCIAL SECURITY NO.: 217-18-1396
17. INFORMANT: RECORDS: BALTIMORE CITY HOSPITALS
ADDRESS: 4940 EASTERN AVE., BALTO., MD. 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 581.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hepatic Coma
DUE TO
(B) Gastro intestinal Bleeding
DUE TO
(C) Severe hepatic cirrhosis & portal hypertension

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-21-67 19 to 12-3- 19 67, that (I) (we) last saw the deceased alive on 12-3-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Mark Lowmiller M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-3-67
23C. PHYSICIAN'S NAME (Type): MARK LOWMILLER MARK Lowmiller M.D.
23D. ADDRESS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 7 1967
24C. NAME of CEMETERY or CREMATORY: St Stanislaus Cemetery
24D. LOCATION (City, town, or county) (State): Dundalk Avenue Balto Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967 Robert E. Farley M.D.
25B. NAME OF REGISTRAR
25C. FUNERAL DIRECTOR: The Dippel Bros Inc
ADDRESS: 1800 E Lombard Street

VS 150-REV. 1/1/65

T-653

67 11631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11631

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Thornton, William Edward

2. DATE AND HOUR OF DEATH 12/4/67 12:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE

D. STREET ADDRESS (If rural, give location) 2917 E. FEDERAL ST.

8-03

5. SEX MALE

6. RACE NEGRO

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED

8. DATE OF BIRTH 6/22/02

9. AGE (In years last birthday) 65

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) West Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Thornton

14. MOTHER'S MAIDEN NAME MARY CALLOWAY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-07-6440

17. INFORMANT Mrs. Ruth Pierce

ADDRESS 406 S. Stokes St Havre De Grace, Md.

MEDICAL CERTIFICATION

1B. 1487

I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Recurrent Squamous Cell Ca of Oropharynx — INTERVAL BETWEEN ONSET AND DEATH: 4½-5mo.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) Infected facial lesion — 1mo

DUE TO

(C) —

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION 7/10/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of mouth

20A. AUTOPSY? (Yes or No) YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/29/67 19 to 12/4 19 67, that (I) (we) last saw the deceased alive on 12:30 PM 12/4 19 67 and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Richard G. Parry M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED 12/4/67

23C. PHYSICIAN'S NAME (Type) RICHARD G. PARRY M.D.

23D. ADDRESS JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE 12/9/67

24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery

24D. LOCATION (City, town, or county) Brooklyn (State) Md.

25A. DATE REC'D BY HEALTH DEPT. DEC 5 1967

25B. NAME OF REGISTRAR Robert E. Fahey M.D.

25C. FUNERAL DIRECTOR Joseph L. Ruth

ADDRESS 2222 W Pratt St 21216

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

50-42-87 IB

I-526

BIRTH NO.

M.E. CASE NO.

67 11632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11632

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): JAMES V Ingraham.

2. DATE AND HOUR OF DEATH: 12/3/67 1:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1016 WEBB COURT 21202

1002

5. SEX: MALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): DIVORCED
8. DATE OF BIRTH: 3-14-91
9. AGE (In years last birthday): 76
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10B. KIND OF BUSINESS OR INDUSTRY: Private Family
11. BIRTHPLACE (State or foreign country): BAHAMA ISLANDS
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES Ingraham
14. MOTHER'S MAIDEN NAME: LUCY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS-BCH-4940 EASTERN AVENUE,
ADDRESS: BALTIMORE, MD. 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 204.2 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Sepsis, Mixed flora — weeks
DUE TO
bacterial Pneumonia.
(B)
DUE TO
(C) Myelomonocytic Leukemia — 10 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/21 1967 to 12/3 1967, that (I) (we) last saw the deceased alive on 12/3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Terry E. Gagon M.D. Attending Phys. ☐ Med. Director ☑ Staff Phys. ☐
23B. DATE SIGNED: 12/3/67
23C. PHYSICIAN'S NAME (Type): DR. TERRY E. GAGON M.D.
23D. ADDRESS: BCH-4940 EASTERN AVENUE-BALTIMORE MD 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/7/67
24C. NAME of CEMETERY or CREMATORY: Mount Auburn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore CO. MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: Herbert E. Nutter
ADDRESS: 3035 W. North Ave.

VS 150-REV. 1/1/65

L-240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11633 Registered No. 67 11633

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) LASHLEY, Tebster Allen or Lester

2. DATE AND HOUR OF DEATH 11-27-67 2:55 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
VETERANS ADMINISTRATION HOSPITAL
3900 LOCH RAVEN BOULEVARD
BALTIMORE, MARYLAND 21218

27

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE CITY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE, MARYLAND
D. STREET ADDRESS (If rural, give location): 437 PATTERSON PARK

6-03

5. SEX: MALE
6. RACE: NEGROID
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: 8-14-37
9. AGE (In years last birthday): 30
If Under 1 Yr. Months Days Hours Min.
If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NEVER EMPLOYED
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: THOMAS SHAW
14. MOTHER'S MAIDEN NAME: ALBERTA LASHLEY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES
(If yes, give war or dates of service): 10-18-55 TO 8-20-57
16. SOCIAL SECURITY NO. 213-34-0095
17. INFORMANT: VET ADMIN HOSP RECORDS
ADDRESS: 3900 LOCH RAVEN BLVD, BALTIMORE, MD 21218

MEDICAL CERTIFICATION

18. 002.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

TUBERCULOSIS, PULMONARY, MODERATELY ADVANCED, ACTIVE. — MONTHS

(A) DUE TO POSSIBLE TUBERCULOUS MENINGITIS — MONTHS

(B) DUE TO DIFFUSE ENCEPHALITIS (ETIOLOGY ?) — MONTHS

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

NONE

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from 11-6-67/6 NOV 19 67 to 27 NOVEMBER 19 67, that (X) (we) last saw the deceased alive on 27 NOVEMBER 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE: David N. Marine M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. XX
23B. DATE SIGNED: 11/30/67

23C. PHYSICIAN'S NAME (Type): DAVID N. MARINE, M.D. M.D.
23D. ADDRESS: 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-4-67
24C. NAME of CEMETERY or CREMATORY: National Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Tankersley
25C. FUNERAL DIRECTOR: Randolph J. Codlick
ADDRESS: 2431 E. Oliver St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
G-650

67 11634

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11634

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HARRY Lee GREEN

2. DATE AND HOUR PRONOUNCED DEAD: November 29, 1967 | 1:33 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Johns Hopkins Hospital D.O.A.

33/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1639 Asquith St.

9-09

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored	Single	6-15-1948	19				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Press Co.	Baltimore, Md.	

13. FATHER'S NAME: Leroy Green

14. MOTHER'S MAIDEN NAME: Edna Hood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): yes

(If yes, give war or dates of service): ?

16. SOCIAL SECURITY NO.: 418-44-9724

17. INFORMANT: Edna Green

ADDRESS: 1639 N. Aisquith St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E981X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot wound of the chest

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES	YES

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Alley

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Harford and Lanvale St.

9-09

21D. TIME OF INJURY (APPROX.): (Month) 11 (Day) 29 (Year) 67 (Hour) 1:30 m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Shot (subject)

22. I certify that I held an Inquiry [P] Inspection [ ] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: November 29, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12-4-67	Mt. Calvary Cmty.	Anne Arundel Co. Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 5 1967	Robert E. Farley M.D.	Randolph J. Collick	2431 E. Oliver St.

VS 151-REV. 1/1/65

N 875 22

1

D-656 67 11635

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11635

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FRANKLIN WALTER DRUMRIGHT

2. DATE AND HOUR PRONOUNCED DEAD: December 3, 1967 | 10:00 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 4800 block Old York Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-03
D. STREET ADDRESS (If rural, give location): 5. S. Schroeder St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored	Single	4-1-1932	35				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): A.A. Co MD

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Bernard Taylor

14. MOTHER'S MAIDEN NAME: Vonnia Drumright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): yes

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: 5 S. Schroeder St — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E891.5

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia

DUE TO Carbon Monoxide Poisoning

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 4800 block Old York Rd. 27-11

21D. TIME OF INJURY (APPROX.): (Month) 12 (Day) 2-3 (Year) 67 (Hour) ? m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Subject found in parked car, windows closed

22. I certify that I held an Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE [signature] M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 3, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/8/67

23C. NAME of CEMETERY or CREMATORY: Balto National

23D. LOCATION (City, town, or county) (State): Balto MD

24A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Marshall P. Hayes — ADDRESS: 638 N Gilmor St

VS 151-REV. 1/1/65

N968.0

W-614

BIRTH NO. 11/20/94 67 11636

M.E. CASE NO. 102139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11636

1. NAME OF DECEASED (Type or Print): WARFIELD, MR. HOWARD R.

2. DATE AND HOUR OF DEATH: 12/2/67 | 11 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BON SECOURS HOSPITAL, FAYETTE & PULASKI Streets

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3719 Keswick Rd.

13-07

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	MARRIED	11/20/94	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: BETH. STEEL

11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: HOWARD R. WARFIELD

14. MOTHER'S MAIDEN NAME: MONROE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 214-05-3146

17. INFORMANT: MARY WARFIELD (SAME) ADDRESS:

MEDICAL CERTIFICATION

I — 1B. 154X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Ca of rectum

DUE TO (B) c widespread metastases

DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH: ~~4 WEEKS~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Bilat. Bronchopneumonia. (days)

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from NOV. 20 1967 to DEC. 2 1967, that ~~I~~ (we) last saw the deceased alive on DEC. 2 1967 and that ~~in my~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12/2/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12-5-67

24C. NAME of CEMETERY or CREMATORY: WAUGH CHAPEL

24D. LOCATION (City, town, or county) (State): HARFORD CO.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Paul L. Clemens

ADDRESS: 3617 Keeler Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-520 67 11637

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11637

1. NAME OF DECEASED (Type or Print): Cora B. King

2. DATE AND HOUR OF DEATH: Dec. 4, 1967 | 10:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 812 Belgian Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-10

D. STREET ADDRESS (If rural, give location): 812 Belgian Ave.

5. SEX: female

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: Nov. 25, 1887

9. AGE (In years last birthday): 80

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Kraft

14. MOTHER'S MAIDEN NAME: Eleanor Mills

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Eleanor Sheeler ADDRESS: Phoenix, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 422.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from December 1966 to December 4, 1967, that (I) (~~we~~) last saw the deceased alive on November 24, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Lloyd E. Saylor M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Dec. 4, 1967

23C. PHYSICIAN'S NAME (Type): Lloyd E. Saylor M.D.

23D. ADDRESS: 3902 Greenmount Avenue

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/7/67

24C. NAME of CEMETERY or CREMATORY: Greenmount Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

25B. NAME OF REGISTRAR: Robert E. Turkey, M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

S-538 67 11638 BALTIMORE CITY HEALTH DEPARTMENT 67 11638

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ERNEST A SCHMIDT

2. DATE AND HOUR PRONOUNCED DEAD: December 4, 1967 10:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-02

D. STREET ADDRESS (If rural, give location): 4707 Blue Ridge Avenue

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced

8. DATE OF BIRTH: April 7, 1887.

9. AGE (In years last birthday): 80

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machinist

10B. KIND OF BUSINESS OR INDUSTRY: Cont. Can Co.

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Rudolf Schmidt

14. MOTHER'S MAIDEN NAME: Emma ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Unk. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-01-5190

17. INFORMANT: Mr. Bernard Peter, 10 Light St. Balto. Md. #2 ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: December 4, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/6/67.

23C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967 Robert E. Farley M.D.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214 ADDRESS

VS 151-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. A-440 67 11639

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11639

1. NAME OF DECEASED (Type or Print): Irene F. Allwell

2. DATE AND HOUR OF DEATH: December 1, 1967 2:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: 00
(If not in hospital or institution, give street address or location): 539 Benninghaus Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21212 27-48
D. STREET ADDRESS (If rural, give location): 539 Benninghaus Road 27-48

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: 1/6/1884
9. AGE (In years last birthday): 83
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Bayne
14. MOTHER'S MAIDEN NAME: Margaret Lastner

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-54-0752
17. INFORMANT: Sylvester S. Allwell
ADDRESS: 803 Evesham Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 450.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Failure
DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from June 30 1967 to Dec 1 1967, that (I) (we) last saw the deceased alive on Dec 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Laurence C. Post M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/4/67
23C. PHYSICIAN'S NAME (Type): Laurence C. Post M.D.
23D. ADDRESS: 6805 York Road

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/4/67
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co.
ADDRESS: 4905 York Road Baltimore, Md. 21212

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 7-650 67 11640

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11640

1. NAME OF DECEASED (Type or Print): Frome, Archer M. FROME, ARCHER, M.

2. DATE AND HOUR OF DEATH: Dec. 5th, 1967 2:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21218
D. STREET ADDRESS (If rural, give location): 3712 Monterey Road

9-03

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 9/26/67 ??
9. AGE (In years last birthday): 73
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Vice-President -Retired
10B. KIND OF BUSINESS OR INDUSTRY: Hamilton Federal Savings & Loan Assoc.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Herman Frome, Sr.
14. MOTHER'S MAIDEN NAME: Katherine Kemmeter

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-03-4075-A
17. INFORMANT: H. Kenneth Fromme — ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1 & 260X

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Cirrhosis of Liver with abd. ascites — 2 wks
DUE TO
(B) Arteriosclerotic cardio-vascular disease with — many years
DUE TO
(C) Cardiac failure — 2 wks

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes mellitus, Pneumonia

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from January 1963 to Dec. 5th 1967, that (I) (~~we~~) last saw the deceased alive on 12/4/67 19 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Hans J. Koetter M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/5/67
23C. PHYSICIAN'S NAME (Type): Hans J. Koetter M.D.
23D. ADDRESS: Md. General Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/9/67
24C. NAME of CEMETERY or CREMATORY: Dulaney Valley Mem. Grds.
24D. LOCATION (City, town, or county) (State): Timonium, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Tankey M.D.
25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co.
ADDRESS: 4905 York Road Balto., Md. 21212

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B-420 67 11641

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11641

1. NAME OF DECEASED (Type or Print): Katherine B. Black

2. DATE AND HOUR OF DEATH: December 4, 1967 | 945 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Hillcrest Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21218
D. STREET ADDRESS (If rural, give location): 3913 Canterbury Road

12-01

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 5/20/1898
9. AGE (In years last birthday): 69
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John J. Buffington
14. MOTHER'S MAIDEN NAME: Lelia Talbot

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-32-6323B
17. INFORMANT: Frank E. Black
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. 722.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I Congestive Heart Failure — 2-3 days
(A) DUE TO Bilateral Pneumonitis — 2 wks
(B) DUE TO Anemia, Nutritional — Gradual onset
(C) Myocardial Insufficiency — " "
Generalized Rheumatoid Arthritis — " "

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): —
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 1957 to Dec 4 1967, that (I) (we) last saw the deceased alive on Dec 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W H Woody M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12-5-67
23C. PHYSICIAN'S NAME (Type): William H. Woody M.D.
23D. ADDRESS: 1403 Park Ave.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/6/67
24C. NAME of CEMETERY or CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Foxley M.D.
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.
ADDRESS: 4905 York Road, Baltimore, Md. 21212

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-432 67 11642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11642

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROBERT T. SHIELDS

2. DATE AND HOUR OF DEATH: November 30, 1967 | 7:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BON SECOUR HOSPITAL

34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: ELKRIDGE - Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): ELKRIDGE 53-00

D. STREET ADDRESS (If rural, give location): 5 SETTER DR. #77

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 7/20/08

9. AGE (In years last birthday): 59

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DISPATCHER

10B. KIND OF BUSINESS OR INDUSTRY: EPES TRANSPORT System

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: GEORGE SHIELDS

14. MOTHER'S MAIDEN NAME: ~~XXXXXXXXX~~ Fannie Jones

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 228-01-6668

17. INFORMANT: Mrs. Martha Shields, 5 Setter Drive

ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

162.1

(A) Respiratory insufficiency — weeks.

DUE TO

(B) Bronchial carcinoma of Left — months.

DUE TO

(C) Lung - Left Pneumonectomy

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11/1/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-/18 1967 to 11/30 1967, that (I) (we) last saw the deceased alive on 11/30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A. Bravo M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 11/30/67

23C. PHYSICIAN'S NAME (Type): CESAR A. BRAVO M.D.

23D. ADDRESS: Bon Secours Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-4-67

24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Fankuna

25C. FUNERAL DIRECTOR: Howard H. Hubbard

ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

1

P-630 67 11643

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11643

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EARL PARROTT

2. DATE AND HOUR PRONOUNCED DEAD: November 29, 1967 10:47 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): St. Agnes Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Balto Co

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Catonsville 53-00

D. STREET ADDRESS (If rural, give location): 103 Maiden Choice Lane #28

40/99

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 2-18-1899

9. AGE (In years last birthday): 68

If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Howard County, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Parrott

14. MOTHER'S MAIDEN NAME: Mertie Bernice Sill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-09-9143

17. INFORMANT: Mrs. Ruth Parrott, 103 Maiden Choice Lane

ADDRESS: 21228

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

420.0

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: November 30, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12-2-67

23C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Howard H. Hubbard

ADDRESS: 4107 Wilkens Avenue 21229

VS 151-REV. 1/1/65

R-400 67 11644

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11644

1. NAME OF DECEASED (Type or Print): MILTON R. RIEHL

2. DATE AND HOUR OF DEATH: 29 NOV 67 10:00 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY OF MARYLAND HOSPITAL

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore City 20-03
D. STREET ADDRESS (If rural, give location): 609 S. Payson St

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Widowed	2-3-1878	XXXX 89				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NOT KNOWN	NOT KNOWN	NOT KNOWN	USA

13. FATHER'S NAME: NOT KNOWN

14. MOTHER'S MAIDEN NAME: NOT KNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): NOT KNOWN

16. SOCIAL SECURITY NO.: NOT KNOWN

17. INFORMANT: PATIENTS CHART — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) PULMONARY EDEMA, CONGESTIVE HEART FAILURE, ASTHMA, ASCITES — INTERVAL BETWEEN ONSET AND DEATH: DAYS

DUE TO

(B) ABDOMINAL DISTENTION SECONDARY TO LOWS, BOWEL PERFORATION

(C) STRANGULATED INGUINAL HERNIA

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 22 NOV 67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: HERNIA

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 20 NOV 1967 to 29 NOV 1967, that (I) (we) last saw the deceased alive on 29 NOV 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sidney L. Stapleton, Jr. M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 29 NOV 67

23C. PHYSICIAN'S NAME (Type): SIDNEY L. STAPLETON, JR M.D.

23D. ADDRESS: UNIV OF MD HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-2-1967

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Howard H. Hubbard — ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. R-543 67 11645

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11645

1. NAME OF DECEASED (Type or Print): Margaret H. Reynolds

2. DATE AND HOUR OF DEATH: 12/3/67 | 7:20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore Gen. Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-04
D. STREET ADDRESS (If rural, give location): 416 Patapsco Ave.

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Feb. 9, 1887
9. AGE (In years last birthday): 80
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Anne Arundel Co., Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: William Helmstetter
14. MOTHER'S MAIDEN NAME: Eva Reinhardt

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ----
17. INFORMANT: John M. Reynolds - same
ADDRESS:

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Myocardial Inf. c̄ CHF — 3 Days
DUE TO
(B) Cerebral Infarction 2° # A — 3 Days
DUE TO
(C) Mitral Insufficiency 2° RHD — Many years

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Bilateral Lower Lobe Pneumonia or Infarction 3 days?

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/30 1967 to 12/3 1967, that (I) (we) last saw the deceased alive on 12/3/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C. Carter M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/3/67
23C. PHYSICIAN'S NAME (Type): Colvin C. Carter M.D.
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-6-1967
24C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: George J. Gonce
ADDRESS: 4001 Ritchie Hgwy., Baltimore

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. C-236

M.E. CASE NO. 67 11646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11646

1. NAME OF DECEASED (Type or Print): CASTRANDA, MARTHA.

2. DATE AND HOUR OF DEATH: Dec. 3rd. 1967 | 1.35 p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 Franklin Square Hospital.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore. 18-02

D. STREET ADDRESS (If rural, give location): 27 N. CAREY ST

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	white	widowed	12-24-86	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	at home	Md.	U. S. A.

13. FATHER'S NAME: John Donski

14. MOTHER'S MAIDEN NAME: Anna ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs Alice Mett

ADDRESS: 888 1/2 W. Lombard St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) A. SCVD. with myocardial ischemia.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
11-29-67	cholecystitis & stones	YES.	Yes.

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-29 1967 to 12-3 1967, that (I) (we) last saw the deceased alive on 12-3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sang Book Lee M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-3-67

23C. PHYSICIAN'S NAME (Type): Sang Book Lee M.D.

23D. ADDRESS: Franklin Square Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/6/67	Holy Cross Cem.	Bklyn, Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Staley M.D.

25C. FUNERAL DIRECTOR: John J. Cowen & Son, Inc.

ADDRESS: 901 Hollins St. Balto. Md.

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-525 67 11647

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11647

1. NAME OF DECEASED (Type or Print): DOROTHY LEE JENKINS

2. DATE AND HOUR OF DEATH: DEC. 4 1967 | 3:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME AND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: XXXXXXXXXXXXXXXX Maryland

B. COUNTY: A.A.C.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, Maryland 52-00

D. STREET ADDRESS (If rural, give location): 602 Alden Street 21225

5. SEX: F

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Wid.

8. DATE OF BIRTH: 3/20/96

9. AGE (In years last birthday): XXXX 71

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): XX Richmond, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Timberlake

14. MOTHER'S MAIDEN NAME: Annie Ellison

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-22-7478

17. INFORMANT: Mrs. Helen M. Gutermuth 602 Alden Street ADDRESS 21225

MEDICAL CERTIFICATION

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) metastatic carcinoma — 5 week

DUE TO

(B) Bronchogenic Carcinoma ??

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from OCT. 27 19 67 to DEC. 4 19 67, that (I) (we) last saw the deceased alive on DEC. 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/4/67

23C. PHYSICIAN'S NAME (Type): NENITA L. SUAREZ M.D.

23D. ADDRESS: Church Home & Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/7/67

24C. NAME of CEMETERY or CREMATORY: Holy Cross Cemetery

24D. LOCATION (City, town, or county) (State): Anne Arundel Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: McCully Funeral Home ADDRESS 237 Patapsco Ave. 21225

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-300

BIRTH NO. 67 11648

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11648

1. NAME OF DECEASED (Type or Print): John O. Hood

2. DATE AND HOUR OF DEATH: November 28, 1967 | M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Melchior Nursing Home 2327 North Charles Street #18

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 28-03
D. STREET ADDRESS (If rural, give location): 1917 Forest Park Avenue 7

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: Dec. 9, 1875
9. AGE (In years last birthday): 91
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Carpenter
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 207-01-1966
17. INFORMANT: Mr. Raymond H. Hood same address
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 466 X

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Emboli
DUE TO
(B) Phlebothrombosis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Urinary Incontinence & Infection

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-10- 1966 to 11-28- 1967, that (I) (we) last saw the deceased alive on 11-28- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Cesar Valle Caveiro M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12-1-67
23C. PHYSICIAN'S NAME (Type): CESAR VALLE CAVERO M.D.
23D. ADDRESS: 8629 Liberty Rd

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/2/67
24C. NAME of CEMETERY or CREMATORY: Lorraine Park Cemetery
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR: Wm. J. Tickner Sons
ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

D-400

BIRTH NO. 67 11649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11649

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARY LOUISE DULL

2. DATE AND HOUR OF DEATH: 11-30-67 | 9.15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

26-36

D. STREET ADDRESS (If rural, give location): 1340 BROENING HIGHWAY 21224

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 12-20-20

9. AGE (In years last birthday): 46

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARRY SHAMAN

14. MOTHER'S MAIDEN NAME: EULA MOORE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Edward W. Dull, 1340 Broening Highway

ADDRESS

CAUSE OF DEATH

18. 490 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral Asperation Pneumonia

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 11/14/67 11/30/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: abd pain + N&V

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): N.A.

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): N.A.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): N.A.

21E. INJURY OCCURRED: While At Work ☐ N.A. Not While At Work ☐

21F. HOW DID INJURY OCCUR? N.A.

22. I certify that (I) (this hospital) attended the deceased from 9/14/67 19 to 11/30 19 67, that (I) (we) last saw the deceased alive on 11/30 19 67 and that In(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: F. J. Scarpa

M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 11/30/67

23C. PHYSICIAN'S NAME (Type): Francis J. Scarpa ~~Bernard Eisenstein~~

M.D.

23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/4/67

24C. NAME of CEMETERY or CREMATORY: First United Evan. Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Sankyma

25C. FUNERAL DIRECTOR: Ullrich Funeral Home Dundalk, Md.

ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released as Non Med. for the Medical Examiner's Office by Dr. Springate

1

12 01 31 AS

DULL, MARY L.

S-150

BIRTH NO. 67 11650

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11650

1. NAME OF DECEASED (Type or Print): SPOHN Mr. William

2. DATE AND HOUR OF DEATH: 11-29-67 4:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Balto C.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 1715 Rita Ave. Rita Rd.

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH: 2-18-99

9. AGE (In years last birthday): 68

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self-Contractor

10B. KIND OF BUSINESS OR INDUSTRY: BUILDING

11. BIRTHPLACE (State or foreign country): PENNA

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Charles Spohn

14. MOTHER'S MAIDEN NAME: Rachel Shindal

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Wm. G. SPOHN JR. ADDRESS: 601 NORTH BEND RD

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 454 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PULMONARY EDEMA

DUE TO

(B) RE-THROMBOSIS of ABDOMINAL AORTA

DUE TO

(C) AORTIC ATHEROSCLEROSIS SEVERE, & SUBTOTAL OCCLUSION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11/27/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Leriche Syndrome

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-25 1967 to 11-29 1967, that (I) (we) last saw the deceased alive on 11-29 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Nabil F. Warsal M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 11-29

23C. PHYSICIAN'S NAME (Type): NABIL F. WARSAL M.D.

23D. ADDRESS: Maryland General Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/2/67

24C. NAME of CEMETERY or CREMATORY: GARDENS OF FAITH

24D. LOCATION (City, town, or county) (State): OVERLEA MD

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: ULRICH FUNERAL HOME

ADDRESS: DUNDALK MD

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. C-426 67 11651

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. X 67 11651

1. NAME OF DECEASED (Type or Print): Ernesto Anthony Caligiura

2. DATE AND HOUR OF DEATH: Dec. 3, 1967 | 9 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hospital, 3100 Wyman Pk. Drive

28

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New York
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Bronx
D. STREET ADDRESS (If rural, give location): ~~1130 Calhoun Ave.~~ 1792 Guion Place

V-29

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Sep.	8/11/08	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Steward Retired	Seafarer	NY	USA

13. FATHER'S NAME: Joseph Caligiura

14. MOTHER'S MAIDEN NAME: Caroline Ferrera (?)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 057-14-4328

17. INFORMANT: Records- US PHS Hospital, Balto, Md.
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 197.9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis due to
DUE TO rhabdomyosarcoma

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)
DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: Months

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I)/(this hospital) attended the deceased from Oct. 11 19 67 to Dec. 3 19 67, that (I)/(we) last saw the deceased alive on Dec. 3 19 67 and that in (my)/(our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William L. Wilkie, Surgeon (R) M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12/4/67

23C. PHYSICIAN'S NAME (Type): William L Wilkie M.D.

23D. ADDRESS: US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12-7-1967	St. Raymond's Cemetery	Bronx, New York

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Howard H. Hubbard, 4107 Wilkens Ave. 21229

RGB

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B-620 67 11652

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. X 67 11652

1. NAME OF DECEASED (Type or Print): Brooks Elizabeth

2. DATE AND HOUR OF DEATH: Nov. 30, 1967 7:Am. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lincoln Memorial Nursing Home 90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Calvert Calvert Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Huntingtown Md 54-00
D. STREET ADDRESS (If rural, give location):

5. SEX: F
6. RACE: N.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: 2-28-1894
9. AGE (In years last birthday): 73 yrs.
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 219-26-2927
17. INFORMANT: Mrs. Ada Rice ADDRESS: Huntingtow n -Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.1

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-27 1967 to 11-30 1967, that (I) (we) last saw the deceased alive on 11-30- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 11-30-67
23C. PHYSICIAN'S NAME (Type): Frank Schwabe M.D.
23D. ADDRESS: 2319 Kennison Av Balt Md

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 12-3 67
24C. NAME of CEMETERY or CREMATORY: Youngs Ch. Cem. 12 3-67
24D. LOCATION (City, town, or county) (State): Huntingtown - Cal. Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Pinkney E. Sewell Prince Fred. Md
ADDRESS:

VS 150-REV. 1/1/65

1

N-425 67 11653

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11653

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARY NELSON

2. DATE AND HOUR PRONOUNCED DEAD: November 29, 1967 | 9:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-16

D. STREET ADDRESS (If rural, give location): 4650 Park Heights Avenue

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH: 1-13-1902

9. AGE (In years last birthday): 65

If Under 1 Yr. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Minnie Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-18-0955

17. INFORMANT: Charles Nelson

ADDRESS: 524 N. Carey St

MEDICAL CERTIFICATION

1B. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic cardiovascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: November 30, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12-4-67

23C. NAME of CEMETERY or CREMATORY: Arlington Mem. Pk.

23D. LOCATION (City, town, or county) (State): Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Phillips Funeral Home

ADDRESS: 1727 N. Monroe St

VS 151-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400

BIRTH NO. 67 11654

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11654

1. NAME OF DECEASED (Type or Print): Katie F. Hall

2. DATE AND HOUR OF DEATH: 12-1-67 | 10:40P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 2310 Edgemont Avenue Baltimore, Maryland 21217

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-04

D. STREET ADDRESS (If rural, give location): 2310 Edgemont Avenue

5. SEX: Female

6. RACE: Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 5-14-99

9. AGE (In years last birthday): 68

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Petter Blaine

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Ada Fisher ADDRESS: 509 S. 9th Ave Mt. Vernon N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Uterus — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO

(B) Carcinomatosis — 2 mos

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-6 1967 to 12-1 1967, that (I) (we) last saw the deceased alive on 12-1-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C Franklin Phillips M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/2/67

23C. PHYSICIAN'S NAME (Type): C Franklin Phillips M.D.

23D. ADDRESS: 548 McMechen St Balto Md

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-5-67

24C. NAME of CEMETERY or CREMATORY: Baltimore National

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 5 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Arlington S. Phillips ADDRESS: 1727 N. Monroe St.

VS 150-REV. 1/1/65

24-49-06 1B

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. L-245 67 11655

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11655

1. NAME OF DECEASED (Type or Print): DONALD C. LAUGHLIN

2. DATE AND HOUR OF DEATH: 12-3-67 | 1:45 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
4-01
D. STREET ADDRESS (If rural, give location): 12. N. Liberty St, Balto 21201

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 5-20-03
9. AGE (In years lost birthday): 64
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Gov't
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Patrick Laughlin
14. MOTHER'S MAIDEN NAME: Helen Corcoran

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): unknown
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-26-5234
17. INFORMANT: RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD
ADDRESS: 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 421.3 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pul insufficiency
DUE TO
(B) COPD
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from 2/15 1967 to 12/5 1967, that (X) (we) last saw the deceased alive on 12/5 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: H. M. Meagher M.D. Attending Phys. ☐ Med. Director ☐ State Phys. ☐
23B. DATE SIGNED: 12/5/67
23C. PHYSICIAN'S NAME (Type): DR. H. M. MEAGHER M.D.
23D. ADDRESS: BCH-4940 EASTERN AVENUE, BALTIMORE, MD. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/6/67
24C. NAME of CEMETERY or CREMATORY: St. Mary's Church Cemetery
24D. LOCATION (City, town, or county): Mt. Carmel (State): Pa.

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Loring Byers
ADDRESS: 8728 Liberty Rd Randallstown Md

VS 150-REV. 1/1/65

B-652

JAMES BARNES 67731

BALTIMORE CITY HEALTH DEPARTMENT

67 11656 **CERTIFICATE OF DEATH**

Registered No. 67 11656

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Barnes, James E

2. DATE AND HOUR OF DEATH: 12/3/67 | 9:25 p. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore Balto Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Parkton 53-00

D. STREET ADDRESS (If rural, give location): Old York Road

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Single	4/7/50	17		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student	-	Maryland	USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Frances McCullum

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-	None	Robert Barnes	1625 Howard Ave. Balto. 21

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released On Approval for the Medical Examiner's Office by Dr. F. Wilson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — 3 days

DUE TO

(B) Left Heart Failure

DUE TO

(C) Tetralogy of Fallot

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Transfusion Reaction

CERTIFICATION APPROVED BY 12-5-67 M.D. CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
11/30/67	Tetralogy of Fallot	Yes	No.

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/24/67 19 to 12/3 19 67, that (I) (we) last saw the deceased alive on 12/3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert D. Pipkin M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/3/67

23C. PHYSICIAN'S NAME (Type): Robert D. Pipkin M.D.

23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/6/67	Holly Hill Memorial Gardens	Baltimore, Md. 21220

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 6 1967	Robert E. Farley M.D.	Bruzdzinski Funeral Home	1407 Eastern Ave.

VS 150-REV. 1/1/65

P-150

BIRTH NO. 67 11657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11657

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PAVONE, CARMEL --

2. DATE AND HOUR OF DEATH: DECEMBER 2, 1967 | 11:20A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL, CATON & WILKENS AVES., BALTIMORE, MARYLAND 21229

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 21227 Balto C

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 5508 CARVILLE AVE.

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	MARRIED	11-14-07	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
EXPEDITER	WESTINGHOUSE	MARYLAND	U.SA

13. FATHER'S NAME: JOSEPH PAVONE

14. MOTHER'S MAIDEN NAME: CATHERINE CARBONE LEVIE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 215 10 7363

17. INFORMANT: ST. AGNES HOSPITAL RECORDS ADDRESS: CATON & WILKENS AVES.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 1658 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Superior vena cava syndrome

DUE TO

(B) Advanced metastatic carcinoma

DUE TO

(C) of lung.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (X) (this hospital) attended the deceased from NOVEMBER 23 19 67 to DECEMBER 2 19 67, that (I) (X) (we) last saw the deceased alive on DECEMBER 2, 1967 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Pablo E. Dibos M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-02-67

23C. PHYSICIAN'S NAME (Type): PABLO E. DIBOS M.D.

23D. ADDRESS: CATON & WILKENS AVES., BALTIMORE, MD. 21229

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12-5-67	Loudon Park Cemetery	Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967

25B. NAME OF REGISTRAR: Robert E. Tarley M.D.

25C. FUNERAL DIRECTOR: Tarley-Greaney 8214 Catonsville, Md.

ADDRESS

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11658 35-89-24 Registered No. 67 11658

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ELVON MONROE FRIEND

ELVON MONROE FRIEND

2. DATE AND HOUR OF DEATH 12/5/67 1:21 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

38 Univ of Md Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Caroline Cty

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Federalsburg 55-00

D. STREET ADDRESS (If rural, give location) Box 108 Smith Street

5. SEX M

6. RACE W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M

8. DATE OF BIRTH Sept. 2, 1904 9/8/04

9. AGE (In years last birthday) 63

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer

10B. KIND OF BUSINESS OR INDUSTRY Sunshine Laundry

11. BIRTHPLACE (State or foreign country) Caroline County Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Friend

14. MOTHER'S MAIDEN NAME Ella S. Phillips

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 213-12-5197

17. INFORMANT Mrs. Mabel S. Friend, Federalsburg, Maryland

ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 356.1

(A) Probable pulmonary embolism

DUE TO

(B) Amyotrophic lateral Sclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/29/67 1967 to 12/5 1967, that (I) (we) last saw the deceased alive on 12/4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE S Z Salan M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED 12/5/67

23C. PHYSICIAN'S NAME (Type) SANDRA Z. SALAN M.D.

23D. ADDRESS Univ of Maryland Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE Dec. 9, 1967

24C. NAME of CEMETERY or CREMATORY Federal Hill Cemetery

24D. LOCATION (City, town, or county) Federalsburg, Maryland (State)

25A. DATE REC'D BY HEALTH DEPT. DEC 6 1967

25B. NAME OF REGISTRAR Robert E. Farley M.D.

25C. FUNERAL DIRECTOR Frampton Funeral Home

ADDRESS Federalsburg Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-1001

BIRTH NO. 67 11659

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11659

1. NAME OF DECEASED (Type or Print) KIPE, EARL H.

2. DATE AND HOUR OF DEATH DECEMBER 3 1967 2:30A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST AGNES HOSPITAL, CATON & WILKENS AV, BALTO MD 21229

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE ELLICOTT CITY 21043 B. COUNTY Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township) MARYLAND 53-00
D. STREET ADDRESS (If rural, give location) 506 OELLA AVENUE

5. SEX MALE
6. RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED
8. DATE OF BIRTH 12/5/92
9. AGE (In years lost birthday) [redacted] 74 — If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Car Operator
10B. KIND OF BUSINESS OR INDUSTRY TRANSIT CO
11. BIRTHPLACE (State or foreign country) ILLINOIS
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN B. KIPE
14. MOTHER'S MAIDEN NAME MARCHIE NUSEMAN
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) YES — (If yes, give war or dates of service) WORLD WAR 1
16. SOCIAL SECURITY NO. 213-10/2905
17. INFORMANT ST AGNES RECORDS — ADDRESS CATON&WILKENS AV

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 331X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CVA

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) HIPERTENSION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DECEMBER 2 1967 to DECEMBER 3 1967, that (I) (We) last saw the deceased alive on DECEMBER 3 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.

23A. SIGNATURE [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED DECEMBER 3 1967
23C. PHYSICIAN'S NAME (Type) DR. G. BRAUN M.D.
23D. ADDRESS ST AGNES HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12/6/1967
24C. NAME of CEMETERY or CREMATORY Baltimore National Cem.
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. DEC 6 1967
25B. NAME OF REGISTRAR [signature]
25C. FUNERAL DIRECTOR Easton Funeral Home — ADDRESS Catonsville Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-5251

BIRTH NO. Great Balto. Med. Ctr. Md. 67 11660

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11660

1. NAME OF DECEASED (Type or Print): Johnson, Baby Girl

2. DATE AND HOUR OF DEATH: 5AM, 12/4/67 | 5A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balt. 53-00

D. STREET ADDRESS (If rural, give location): 2901 Andora Ct. Apt E. 21245 34

5. SEX: F

6. RACE: Cau.

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Infant

8. DATE OF BIRTH: 12/2/67

9. AGE (In years last birthday): If Under 1 Yr. Months: Days: 2 | If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Johnson, Edwin T.

14. MOTHER'S MAIDEN NAME: Not Available married name Johnson, Glenda R. GLENDA REGINA KILGORE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: MR. EDWIN T. JOHNSON ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

754.51

(A) Congenital Heart Disease

DUE TO

(B) Hypoplastic Left Heart Syndrome

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Pneumonitis

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: 12/3/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Cong. Heart Dis. Card. Cath.

20A. AUTOPSY? (Yes or No): Yes pending

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (~~this hospital~~) attended the deceased from Dec 2 1967 to Dec 4 1967, that (I) (~~we~~) last saw the deceased alive on Dec 4 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Joseph H. Richman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: Dec. 4, 67

23C. PHYSICIAN'S NAME (Type): Joseph H. Richman M.D.

23D. ADDRESS: Sinai Hospital Drs. Residence

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/5/1967

24C. NAME of CEMETERY or CREMATORY: Good Shepherd

24D. LOCATION (City, town, or county) (State): Ellicott City, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967

25B. NAME OF REGISTRAR: Robert E. Farley

25C. FUNERAL DIRECTOR: Easton Funeral Home Catonsville Md

ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-1621

BIRTH NO. 67 11661

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11661

1. NAME OF DECEASED (Type or Print): Louis G. Jeffries Sr.

2. DATE AND HOUR OF DEATH: Dec. 2, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 3717 2nd. St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 23-04
D. STREET ADDRESS (If rural, give location): 3717 2nd. St.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: June 17, 1891
9. AGE (In years last birthday): 76
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipping Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Metal
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James E. Jeffries
14. MOTHER'S MAIDEN NAME: Annie Donaldson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Louis G. Jeffries Jr. ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis
DUE TO
(B) Myocardial Disease
DUE TO
(C) Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Jan 1964 19 64 to December 2 19 67, that (I) (~~we~~) last saw the deceased alive on November 6 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Mario J. Reda M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/5/67
23C. PHYSICIAN'S NAME (Type): MARIO J. REDA M.D. M.D.
23D. ADDRESS: 4016 RITCHIE HWY BALTO. MD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12 5 67
24C. NAME of CEMETERY or CREMATORY: Glen Haven
24D. LOCATION (City, town, or county) (State): Glen Burnie, A. A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR: Mc Cully ADDRESS: 237 Pat. Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

50-64-20 B

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. K-512 67 11662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11662

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Edmund Kempsell

2. DATE AND HOUR OF DEATH: 12/3/67 1:30 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224 — 31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: HARFORD Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ABERDEEN - 62-28
D. STREET ADDRESS (If rural, give location): 171 W. DEAN AVENUE, 21001

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 8-27-96
9. AGE (In years last birthday): 71
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Engineer (Ret.)
10B. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11. BIRTHPLACE (State or foreign country): ENGLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM KEMPSELL
14. MOTHER'S MAIDEN NAME: JULIA COCKERTON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WW-I
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD
ADDRESS 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

200.1 + 1008.0

(A) DUE TO: UREMIA - PANCYTOPENIA — INTERVAL BETWEEN ONSET AND DEATH: days.

(B) DUE TO: PNEUMONITIS

(C): ? Tuberculosis, ? Lymphoma

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/24 1967 to 12/3 1967, that (I) (we) last saw the deceased alive on 12/3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Terry E. Gagon M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/3/67
23C. PHYSICIAN'S NAME (Type): DR. TERRY E. GAGON M.D.
23D. ADDRESS: BCH-4940 EASTERN AVENUE, BALTIMORE, MD. 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-6-67
24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Walter Macomber Jr.
ADDRESS: Tarring Funeral Home, Aberdeen, Maryland

VS 150-REV. 1/1/65

W-5 1 2 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11663 Registered No. 67 11663

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WEIMASTER, Joseph Carl

2. DATE AND HOUR OF DEATH: 3 DECEMBER 1967 | 3:24 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETERANS ADMINISTRATION HOSPITAL, 3900 LOCH RAVEN BOULEVARD, BALTIMORE, MARYLAND 21218

27

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: BALTIMORE CITY Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 1805 ABERDEEN ROAD, APT. D

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	CAUCASION	MARRIED	11-3-93	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LINOTYPE OPERATOR	PRINTING INDUSTRY	LUTHERVILLE, MARYLAND	U. S. A.

13. FATHER'S NAME: JOSEPH WEIMASTER, SR.

14. MOTHER'S MAIDEN NAME: OTELIA FRAZIER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	6-2-17 TO 6-4-19	212-01-88-28	HOSPITAL RECORDS	3900 LOCH RAVEN BLVD., BALTIMORE, MD. 21218

MEDICAL CERTIFICATION

18. 260 X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A) Pulmonary edema	Days
DUE TO (B) Myocardial infarction	Week
DUE TO (C) Diabetes mellitus	Years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 10

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 16 NOVEMBER 19 67 to 3 DECEMBER 19 67, that (I) (we) last saw the deceased alive on 3 DECEMBER 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: N Bayadi M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12-3-67

23C. PHYSICIAN'S NAME (Type): Nagui R. El-Bayadi M.D.

23D. ADDRESS: 3900 LOCH RAVEN BOULEVARD, BALTIMORE, MARYLAND 21218

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Dec. 6, 1967	Baltimore National Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 6 1967	Robert E. Farley, M.D.	John Burns' Sons	Towson, Maryland

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
M-500

67 11664 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11664

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM J. MOAN

2. DATE AND HOUR PRONOUNCED DEAD: December 1, 1967 | 5:15 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): St. Agnes Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 20 07
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3610 OldFRedERICK Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Single	Feb. 13, 1905	~~57~~ 62				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Male Nurse	Hosp.	Balto. Md.	U.S. A.

13. FATHER'S NAME: James J. Moan

14. MOTHER'S MAIDEN NAME: Margaret M. Reilly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-09-4069

17. INFORMANT: Mrs. Mary M. Picket Rt. 108 Clarksville, ADDRESS: Howard Co. Md. 21029

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	YES

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 2, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	Dec.5,1967	New Cathedral Cem.	Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 6 1967	Robert E. Farberman	G. Truman Schwab	3512 Frederick Ave. Balto. Md.

VS 151-REV. 1/1/65

1

G-360

67 11665 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11665

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM M. GAITHER

2. DATE AND HOUR PRONOUNCED DEAD: November 30, 1967 4:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 40/99 St. Agnes Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: HOWARD

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ellicott City 63-00

D. STREET ADDRESS (If rural, give location): 289 Columbia Pike

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): single

8. DATE OF BIRTH: 3/21/03

9. AGE (In years last birthday): 64 ~~65~~

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): chief clerk

10B. KIND OF BUSINESS OR INDUSTRY: Circut Court

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William B. Gaither

14. MOTHER'S MAIDEN NAME: Carrie Hobbs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Mrs Robert Allport

ADDRESS: 21 Norwood Ave Sykesville, Md. 21784

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D.

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED December 1, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): burial

23B. DATE: 12/3/67

23C. NAME of CEMETERY or CREMATORY: Springfield

23D. LOCATION (City, town, or county) (State): Sykesville, Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967

24B. NAME OF REGISTRAR: Robert E. Farkey M.D.

24C. FUNERAL DIRECTOR: Higinbothom Slack Funeral Home

ADDRESS: Ellicott City, Md.

VS 151-REV. 1/1/65

M1250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

67 11666

Registered No. 67 11666

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MICHNO MR PETER. I.

2. DATE AND HOUR OF DEATH: 12. 3. 67 | 7-45P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 35 CHURCH HOME AND HOSPITAL 1000 BROADWAY BALTIMORE MD 21231

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 26-36

D. STREET ADDRESS (If rural, give location): 1411 DUNDALK AVENUE

5. SEX: M

6. RACE: W.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED.

8. DATE OF BIRTH: 2. 16. 01

9. AGE (In years last birthday): 66

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GROCER.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND,

12. CITIZEN OF WHAT COUNTRY? AMER.

13. FATHER'S NAME: JACOB MICHNO

14. MOTHER'S MAIDEN NAME: CAROLINA AUGUSTINAK.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): UNKNOWN

16. SOCIAL SECURITY NO.: 215 324110

17. INFORMANT

ADDRESS

MEDICAL CERTIFICATION

1B. 223 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Cardiac arrest.

DUE TO

(B) Hygroma of brain

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Anemia.

19A. DATE OF OPERATION: Nov. 29th/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Suspected subdural hematoma

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 11/17/ 1967 to 12/3 1967, that (I) (we) last saw the deceased alive on 12/3/ 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S Albina M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/3/67

23C. PHYSICIAN'S NAME (Type): ALBINA M.D.

23D. ADDRESS: Church Home & Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-7-67

24C. NAME of CEMETERY or CREMATORY: St Stanislaus Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Walter Dabrowski

ADDRESS: 1005 Dundalk Avenue

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
C-560

67 11667

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11667

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): VONDER J. CONNER

2. DATE AND HOUR PRONOUNCED DEAD: December 3, 1967 9:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Church Home & Hospital (DOA)

35/11

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-02
D. STREET ADDRESS (If rural, give location): 229 S. Ann Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	1-11-19	48				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shipyard Worker	Shipbuilding	Maryland	USA

13. FATHER'S NAME: Raymond Conner

14. MOTHER'S MAIDEN NAME: Martha Bridges

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unk

16. SOCIAL SECURITY NO.: 212181235

17. INFORMANT: Ziegler Funeral Home ADDRESS: Hyndman, Pa

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: December 4, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12-7-67	Hyndman Cem	Hyndman Pa

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 6 1967	Robert E. Farley M.D.	Burger Funeral Home By Vance W. Burger Jr	3631 Falls Rd Balto

VS 151-REV. 1/1/65

1
m-324

67 11668 BALTIMORE CITY HEALTH DEPARTMENT 67 11668

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM T. MITCHELL

2. DATE AND HOUR PRONOUNCED DEAD: December 3, 1967 | 2:45 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1615 Westwood Ave. D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 15-01 1615 Westwood Ave. D.O.A.

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): married
8. DATE OF BIRTH: 3-29-25
9. AGE (In years last birthday): 42
If Under 1 Yr. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm. Mitchell
14. MOTHER'S MAIDEN NAME: Bertha Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 191-14-1400
17. INFORMANT: Winona Mitchell ADDRESS: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 443 X
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intracerebral hemorrhage
~~XXXXXXX~~

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertensive Cardiovascular Disease
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 21
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Edward F. Wilson, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: December 3, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12/8/67
23C. NAME of CEMETERY or CREMATORY: Balto. Nat'l. Cem.
23D. LOCATION (City, town, or county) (State): Balto., Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
24B. NAME OF REGISTRAR
24C. FUNERAL DIRECTOR: Kelson Funeral Home ADDRESS: 1348 Calhoun St.

VS 151-REV. 1/1/65

N-1001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11669

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11669

1. NAME OF DECEASED (Type or Print): Newby, Elizabeth F.

2. DATE AND HOUR OF DEATH: 12-4-67 1:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc.
39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 14-02
D. STREET ADDRESS (If rural, give location): 1700 McCulloh Street

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: 11-28-09
9. AGE (In years last birthday): 58
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alonzo Newby
14. MOTHER'S MAIDEN NAME: Vashti Haze

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Rev. Russell Newby - Brother
ADDRESS: SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

18. 331X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage
DUE TO
(B) Hem-plegia, left
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from November 24, 1967 to December 4, 1967, that (I) (we) last saw the deceased alive on December 4, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Laredo M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-4-67
23C. PHYSICIAN'S NAME (Type): DR. C. LAREDO M.D.
23D. ADDRESS: 1514 Division Street Balto., Maryland

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/7/67
24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Pk.
24D. LOCATION (City, town, or county) (State): Arbutus, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Kelson Funeral Home
ADDRESS: 1348 Calhoun St

VS 150-REV. 1/1/65

1
B-424

67 11670 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11670

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HOWARD TAFT BLACKWELL

2. DATE AND HOUR PRONOUNCED DEAD: December 4, 1967 10:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 851 George St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-03

D. STREET ADDRESS (If rural, give location): 851 George St. Apt. 9-H

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Married. Married	10/2/09	58				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Steel	Virginia	U S A

13. FATHER'S NAME: Lynn Bla ckwell

14. MOTHER'S MAIDEN NAME: Kate Brent

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): ?

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Verniece Blackwell, same

ADDRESS:

MEDICAL CERTIFICATION

18. 422.1

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection XX Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes X Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER X

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 12/5/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/9/67	Arbutus Mem Park	Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 6 1967	Robert E. Fankey M.D.	Adolphus Halstead	1206 W North AVe

VS 151-REV. 1/1/65

T-52d

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 11671 **CERTIFICATE OF DEATH** Registered No. 67 11671

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BLANCHE THOMAS

2. DATE AND HOUR OF DEATH: 12-5-67 | 6:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 LUTHERAN HOSPITAL OF MD. 730 ASHBURTON St. BALTIMORE MD 21216

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: 16-09
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1501 DUKELAND St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	C	WID.	10-31-1901	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker		St. Mary Co. Md.	

13. FATHER'S NAME: unk.

14. MOTHER'S MAIDEN NAME: Maggie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 228-05-5841

17. INFORMANT: Donald Nolan CHART ADDRESS: 2204 Brechburg St.

MEDICAL CERTIFICATION

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 443 X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebro vascular Accident

DUE TO

(B)

DUE TO

(C) Hypertensive Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-24-67 19 to 12-5 1967, that (I) (we) last saw the deceased alive on 12-5-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: S. Aziz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type): S. AZIZ M.D.

23D. ADDRESS: 730 ASHBURTON St. Baltimore, MD 21216

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/8/67	Arbutus Mem Pk.	Arbutus Md.

25A. DATE REC'D BY HEALTH DEPT. DEC 6 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: Earl Gilmore ADDRESS: 1827 W. North Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-420

BIRTH NO. 67 11672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11672

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANNA B. BLOSS.

2. DATE AND HOUR OF DEATH: MON. 12-4-67 | 7:45 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 21-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21230.
D. STREET ADDRESS (If rural, give location): 1128 W. Hamburg St.

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow.
8. DATE OF BIRTH: 8-7-04.
9. AGE (In years last birthday): 63.
10. Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Nurses Aid-
10B. KIND OF BUSINESS OR INDUSTRY: St. Agnes Hospital
11. BIRTHPLACE (State or foreign country): Balto, Maryland.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John T. Price
14. MOTHER'S MAIDEN NAME: Mary Agnes Jacobs.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-18-6243
17. INFORMANT: Betty L. Bloss - (Daughter) ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I. 1B. 570.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) shock — 10 hr
DUE TO
(B) hypovolemia and/or endotoxin — 10 hr.
DUE TO
(C) intestinal infarction

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. RHD, E mitral stenosis

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-3 19 67 to 12-4 19 67, that (I) (we) last saw the deceased alive on 12-4 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard H. Reed M.D. — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12-5-67
23C. PHYSICIAN'S NAME (Type): Richard H. Reed M.D.
23D. ADDRESS: 1213 Light St.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: Dec 8-8-67 Fri
24C. NAME OF CEMETERY or CREMATORY: Loudon Park Cem
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: CURTIS E. EVANS
ADDRESS: 1400 S Charles 21230

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-250

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11673

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): NIXON, FLORENCE ESTHER

2. DATE AND HOUR OF DEATH: DECEMBER 5, 1967 1:15A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST AGNES HOSPITAL, CATON & WILKENS AVENUES, BALTIMORE, MARYLAND 21229

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE Balto Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): CATONSVILLE 21228 53-00
D. STREET ADDRESS (If rural, give location): 315 INGLESIDE AVENUE

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 09-10-98
9. AGE (In years last birthday): 69
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: CHARLES WALTEMEYER
14. MOTHER'S MAIDEN NAME: MAMIE ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: 214 56 0133
17. INFORMANT: ST AGNES' RECORDS ADDRESS: CATON & WILKENS AVES

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 570.5 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO Intestinal obstruction

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Generalized arteriosclerosis

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 25 19 67 to DECEMBER 5 19 67, that (X) (we) last saw the deceased alive on DECEMBER 5 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.

23A. SIGNATURE: Rolando M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X
23B. DATE SIGNED: 12/5/67
23C. PHYSICIAN'S NAME (Type): ROLANDO DEL ROSARIO M.D.
23D. ADDRESS: ST AGNES HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12-8-67
24C. NAME of CEMETERY or CREMATORY: Cedar Hill
24D. LOCATION (City, town, or county) (State): Anne Arundel Cty Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967
25B. NAME OF REGISTRAR: Robert E. Kelley, M.D.
25C. FUNERAL DIRECTOR: Geo L. Schwab Funeral Home
ADDRESS: Francis H. Miller 2101 Frederick Ave.

VS 150-REV. 1/1/65

5-531

BIRTH NO. 67 11674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11674

M.E. CASE NO.

CERTIFICATE AMENDED 12/11/67

1. NAME OF DECEASED (Type or Print): Charles Edward Sanders

2. DATE AND HOUR OF DEATH: Dec 4 ~~1967~~ 1967 3:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
A. HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00
B. ADDRESS: 7 N Beechfield Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: ~~7 N Beechfield Ave~~
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 7 N. Beechfield Ave. 28-04

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Dec 17-1893
9. AGE (In years last birthday): 73
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Comptroller
10B. KIND OF BUSINESS OR INDUSTRY: U S Gov.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: — Sanders
14. MOTHER'S MAIDEN NAME: Harriet Salters

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): World War
16. SOCIAL SECURITY NO.: 217-24-3746
17. INFORMANT: Mrs Ina E Sanders
ADDRESS: 3719 4th St

MEDICAL CERTIFICATION

18. I 4201
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary Thrombosis — instantly
DUE TO
(B) Arteriosclerotic C.V.D. — years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 1946 to Dec 4 1967, that (I) (we) last saw the deceased alive on Nov 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J C Pouns M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/5/67
23C. PHYSICIAN'S NAME (Type): J. C. Pouns M.D.
23D. ADDRESS: 332 S Frederick Av.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-7-67
24C. NAME of CEMETERY or CREMATORY: Balto National
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: E. L. Schwab Funeral Home
ADDRESS: Francis H. Miller 2101 Frederick Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Letter from Dr. J. C. Pound re date of death — stated be "Dec. 4, 1967".

G 650 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11675

Registered No. 67 11675

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES GREEN, Jr.

2. DATE AND HOUR OF DEATH: 12/4/67 4:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 7-04
D. STREET ADDRESS (If rural, give location): 1021-N. Wolfe St.

5. SEX: Male
6. RACE: Negroid
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 6/25/26
9. AGE (In years last birthday): 41
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONSTRUCTION WORK
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): PUTNAM, GEORGIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Green
14. MOTHER'S MAIDEN NAME: Roberta Wilson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Dorothy Green
ADDRESS: 1120 Wicklow Road

MEDICAL CERTIFICATION

18. 331 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: INTRACEREBRAL HEMORRHAGE — ? 6 HRS

(B) DUE TO: HYPERTENSION — ? >24 RS

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/3 1967 to 12/4 1967, that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harry K. Genant M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/4/67
23C. PHYSICIAN'S NAME (Type): Harry K. Genant M.D.
23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12-7-67
24C. NAME of CEMETERY or CREMATORY: Baltimore Nat'l Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Lerbeman
25C. FUNERAL DIRECTOR: MORTON & DYETT F.H.
ADDRESS: 1701 Laurens St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released as Non Med. for the Medical Examiners Office by Dr. Springate

on

(8)

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. D-141

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

67 11676 CERTIFICATE OF DEATH

Registered No. 67 11676

1. NAME OF DECEASED (Type or Print): James Clark Devilbiss Jr

2. DATE AND HOUR OF DEATH: 12/5/67 10:20 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Maryland Hosp 38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balt. City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 28-01
D. STREET ADDRESS (If rural, give location): 827 Glen Allen dr.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 6/8/08
9. AGE (In years lost birthday): 59
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Mgr
10B. KIND OF BUSINESS OR INDUSTRY: Meat Pkging
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James C Devilbiss Sr
14. MOTHER'S MAIDEN NAME: Margaret E. Abrecht

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNK
(If yes, give war or dates of service): 214-09-4151 ~~UNK~~
16. SOCIAL SECURITY NO.
17. INFORMANT: ~~UNK~~ UNK
ADDRESS: Mrs. James Develbiss, 829 Glen Allen Dr.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 451X

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Abdominal aneurysmectomy — 5 days
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HCVD — years

19A. DATE OF OPERATION: 11/30/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Abdominal aneurysm
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/9 1967 to 12/5 1967, that (I) (we) last saw the deceased alive on 12/5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: NC Bosch M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): Nicholas C. Bosch M.D.
23D. ADDRESS: University of Maryland Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/8/67
24C. NAME of CEMETERY or CREMATORY: Rose Hill Cem.
24D. LOCATION (City, town, or county) (State): Hagerstown, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Fallaya
25C. FUNERAL DIRECTOR: Witzke F. D. - 4101 Edmondson Ave.
ADDRESS

VS 150-REV. 1/1/65

(4)

BIRTH NO. A-536 67 11677

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11677

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Bertha Anderson

2. DATE AND HOUR OF DEATH: Dec. 3, 1967 | 8 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Anderson Conv. Home 3604 Mohawk Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give town): Baltimore
D. STREET ADDRESS (If rural, give location): Anderson Conv. Home 3604 Mohawk Ave.

28-41

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	Wh	Widowed	9/25/86	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ----Pfeiffer

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Elizabeth P. Anderson
ADDRESS: Apt. 20K, 343 E. 30th St.-New York, N. Y.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 450.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia
DUE TO
(B) Generalized arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Senility

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 3rd 1960 to Dec 3rd 1967, that (I) (we) last saw the deceased alive on Dec 13th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: M. Paul Byerly M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): M. Paul Byerly M.D.

23D. ADDRESS: 5820 York Rd.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/6/67

24C. NAME of CEMETERY or CREMATORY: Pine Grove Cem.

24D. LOCATION (City, town, or county) (State): Mt. Airy, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Witzke F. D. - 4101 Edmondson Av.

ADDRESS

VS 150-REV. 1/1/65

(9) 1

BIRTH NO. B-435 67 11678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11678

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): James Bolton, JR.

2. DATE AND HOUR OF DEATH: Dec. 4, 1967 | 6:35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore City

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 400 Old Orchard Rd.

28-04

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Divorced	4/27/25	42		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machine Adjuster	Balto. Envelope	Ohio	USA

13. FATHER'S NAME: JAMES BOLTON, SR.

14. MOTHER'S MAIDEN NAME: ESTHER Chappo

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-20-3331

17. INFORMANT: Mr. Eugene G. Bolton ADDRESS: 400 Old Orchard Rd.

MEDICAL CERTIFICATION

1B. 420.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial Infarction — 1 hour

DUE TO

(B) HASCVD — Several years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	Yes	No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ ~~Not While~~ At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 1 1967 to Dec. 4 1967, that (I) (we) last saw the deceased alive on Dec. 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John D. Graber M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: Dec. 4, 1967

23C. PHYSICIAN'S NAME (Type): John D. Graber M.D.

23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/7/67	New Cathedral Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 6 1967	Robert E. Turkey M.D.	Witzke F. D.	4101 Edmondson Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

27 01 48 RS

P-452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11679 Registered No. 67 11679

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Catherine H. Polomski

2. DATE AND HOUR OF DEATH: 12-2-67 - 7 05 p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): North Charles Hosp.

49

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: — 24-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1127 Hull St. -

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): W
8. DATE OF BIRTH: 10-20-90
9. AGE (In years last birthday): 77
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Skinner
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? Poland

13. FATHER'S NAME: Michael Polomski
14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 213-18-6678
17. INFORMANT: Chart N. CH G. Hosp. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) aspiration vomitin — 12-2-67

DUE TO

(B) intestinal obstruction — 11-29-67

DUE TO

(C) Abdominal tumor — 11-29-67

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 12-2 19 67 to 12-2 19 67, that (I) (we) last saw the deceased alive on 12-2-67 at 7pm and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Luis Renfel M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-2-67
23C. PHYSICIAN'S NAME (Type): Walter Kohn M.D.
23D. ADDRESS: North Charles Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/6/67
24C. NAME of CEMETERY or ~~CREMATORY~~: Holy Rosary Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Charles L. Stevens Funeral Home, Inc. ADDRESS: 1501 E. Fort Avenue

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M 2461

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11680

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11680

1. NAME OF DECEASED (Type or Print): McELROY, CLARA

2. DATE AND HOUR OF DEATH: 12-5-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION: 34 Bon Secour Hosp (If not in hospital or institution, give street address or location) 2025 W Fayette St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): CATONSVILLE 53-00
D. STREET ADDRESS (If rural, give location): 617 Coleraine Rd #29

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 10-4-1890
9. AGE (In years last birthday): 76
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE-WIFE
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lemuel Cook
14. MOTHER'S MAIDEN NAME: Haines, Jennie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: GRACE McELROY
ADDRESS: 4410 ROKEBY RD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) acute pulmonary edema.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

527.2

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11-9-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Poor
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9-27-67 19 to 12-5-67 11:32 a.m. 19, that (I) (we) last saw the deceased alive on 11:32 a.m. 12-5-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: M. Mohamad M.D. Attending Phys. ☐ Med. Director ☒ Staff Phys. ☐
23B. DATE SIGNED: 12-5-67 11:32 a.m.
23C. PHYSICIAN'S NAME (Type): DR Nelson McKay M.D.
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12-8-67
24C. NAME of CEMETERY or CREMATORY: WOODLAWN CEMETERY
24D. LOCATION (City, town, or county) (State): BALTO MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: WEBER FUNERAL HOME
ADDRESS: 5311 EDMONDSON AVENUE.

VS 150-REV. 1/1/65

V-410

BIRTH NO. 67 11681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11681

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): VOELP, LOUISE

2. DATE AND HOUR OF DEATH: 12-4-67 | 4 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hospital of Maryland 46

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore C
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, Maryland 53-00
D. STREET ADDRESS (If rural, give location): 2029 Englewood Ave

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 3/5/1888
9. AGE (In years last birthday): 79
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Mattheisz
14. MOTHER'S MAIDEN NAME: Katherine Bender

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-05-7357
17. INFORMANT: Carl W. Voelp
ADDRESS: Same as # 4

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
522 X

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 24 h

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B)

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: ✓
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): ✓
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): ✓

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): ✓
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-4- 1967 to 4 PM 12-4- 1967, that (I) (we) last saw the deceased alive on 4 PM 12-4- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-4-67
23C. PHYSICIAN'S NAME (Type): NGUYEN THI OANH M.D.
23D. ADDRESS: Lutheran Hospital of Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/7/67
24C. NAME of CEMETERY or CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: J. T. STANSBURY ADDRESS: 6411 Windsor Mill Rd Woodlawn Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B-653 67 11682

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11682

1. NAME OF DECEASED (Type or Print): EMORY BRYANT

2. DATE AND HOUR OF DEATH: DECEMBER 5, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 3402 BATEMAN AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-38
D. STREET ADDRESS (If rural, give location): 3402 BATEMAN AVENUE

5. SEX: MALE
6. RACE: COLORED
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): DIVORCED
8. DATE OF BIRTH: OCT. 3, 1884
9. AGE (In years last birthday): 83
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Post Office
11. BIRTHPLACE (State or foreign country): PENSACOLA, FLORIDA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emory Bryant, Sr.
14. MOTHER'S MAIDEN NAME: Elizabeth Green

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: NATHANIEL HIGHTOWER
ADDRESS: 3402 BATEMAN AVE.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 151X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — ?
DUE TO

(B)
DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct. 24 1967 to Dec 5 1967, that (I) (we) last saw the deceased alive on Dec 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We) (did)~~ (did not) view the body after death.

23A. SIGNATURE: Frederick K. Adams M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Dec 5 1967
23C. PHYSICIAN'S NAME (Type): FREDERICK K. ADAMS M.D.
23D. ADDRESS: 1222 N. Caroline St. Balto Md 21213

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12-10-67
24C. NAME OF CEMETERY or CREMATORY: EVERGREEN CEMETERY
24D. LOCATION (City, town, or county) (State): JACKSONVILLE, FLORIDA

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: CHARLES R. LAW
ADDRESS: 802 MADISON AVE., BALTO, MD.

VS 150-REV. 1/1/65

B-260 1

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 11683 **CERTIFICATE OF DEATH** Registered No. 67 11683

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BUCHER JOSEPH R

2. DATE AND HOUR OF DEATH: DECEMBER 4, 1967 11:20 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 BON SECOURS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: HOWARD Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Rural, Marriottsville 63-00
D. STREET ADDRESS (If rural, give location): Marriottsville Road 21104

5. SEX: MALE
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 8/10-1904
9. AGE (In years last birthday): 63
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERICAL
10B. KIND OF BUSINESS OR INDUSTRY: State Roads Md
11. BIRTHPLACE (State or foreign country): BALTO Md
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Richard L. Bucher
14. MOTHER'S MAIDEN NAME: Owensy Dixon

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.:
17. INFORMANT: Patrick J. Bucher — ADDRESS: Marriottsville Rd Marriottsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Generalized peritonitis DUE TO
(B) Perforated duodenal ulcer DUE TO — few days
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 13 1967 to December 4 1967, that (I) (~~we~~) last saw the deceased alive on December 4 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Melvin N. Braden M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/5/67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS: 5000 Balto. National Pike Baltimore, Maryland 21229

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/9/67
24C. NAME of CEMETERY or CREMATORY: New Cathedral Cem
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Farkas M.D.
25C. FUNERAL DIRECTOR: Thomas J. Kerney Inc. ADDRESS: Rec Hollins

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11684 Registered No. 67 11684

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Johnson, Mollie Ball

2. DATE AND HOUR OF DEATH: Dec. 5, 1967 | 2:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Balt. City

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 8-07

D. STREET ADDRESS (If rural, give location): 1444 N. Gay Street

5. SEX: F

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Oct. 29, 1912

9. AGE (In years last birthday): 55

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Farmville, Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Jeffries

14. MOTHER'S MAIDEN NAME: Mary Crosby

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Daughter - Mary Jackson - ADDRESS: 1444 N. Gay

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical ~~examiner~~)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ ~~Not While At Work~~ ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from Dec. 5 19 67 to — 19 , that (I) (we) last saw the deceased alive on Dec. 5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John D Graber M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: Dec. 5, 1967

23C. PHYSICIAN'S NAME (Type): John D. Graber M.D.

23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-8-67

24C. NAME of CEMETERY or CREMATORY: Balto Nat Cem

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967

25B. NAME OF REGISTRAR: Robert E. Tedeschi M.D.

25C. FUNERAL DIRECTOR: Thos A Wilson

ADDRESS: 1000 Brantley Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J 1525

67 11685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11685

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HERBERT JOHNSON

2. DATE AND HOUR OF DEATH: 12-5-67 | 1:20 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYALND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 605

D. STREET ADDRESS (If rural, give location): 233 N. DALLAS CT.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	NEGROID	married	1-23-96	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	None	N. Carolina	USA

13. FATHER'S NAME: HENRY

14. MOTHER'S MAIDEN NAME: JANE Johnson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

18. 422.1

(A) Arteriosclerotic cardiovascular disease. — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Chronic active hepatitis

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/4 1967 to 12/5 1967, that (I) (we) last saw the deceased alive on 12/5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: G. Michael Vincent M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12/5/67

23C. PHYSICIAN'S NAME (Type): G. MICHAEL VINCENT M.D.

23D. ADDRESS: Johns Hopkins Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12-9-67	Mt Auburn Cem	Brooklyn Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 6 1967	Robert E. Fackenthal M.D.	Chas O Weber	100 Brantly Ln

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

OSL 3

123 67

L-125

BIRTH NO. 67 11686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11686

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Junius L. Lipscomb

2. DATE AND HOUR OF DEATH: 3rd Dec 1967 | 9:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2003 N Wolfe St. Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 2003 N Wolfe St.

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Married	9/8/95	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Crane Opr (Retired)		Virginia	U.S.

13. FATHER'S NAME: George Lipscomb

14. MOTHER'S MAIDEN NAME: Lavinia

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): World War I

16. SOCIAL SECURITY NO.: 213-07-6953

17. INFORMANT: Wife — ADDRESS: Same as Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: Unknown.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
10/6/67	Carcinoma of Pancreas	No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from August 1967 to 3rd Dec 1967, that (I) (we) last saw the deceased alive on 3rd Dec 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alvin Thompson M.D. — Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/3/67

23C. PHYSICIAN'S NAME (Type): Alvin Thompson M.D.

23D. ADDRESS: 1856 N. Wolfe St. Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	12-7-67	Arbutus Cem	Arbutus	Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 8 1967	Robert E. Fox, M.D.	Elroy O. Wilson	1000 Brantley Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

S-363

67 11687 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11687

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): STELLA STEWART

2. DATE AND HOUR PRONOUNCED DEAD: November 29, 1967 3:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 11 N. Eden Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore S-01

D. STREET ADDRESS (If rural, give location): 11 N. Eden Street

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): single

8. DATE OF BIRTH: 12-16-1892

9. AGE (In years last birthday): 74

If Under 1 Yr. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Castleshore Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eley Stewart

14. MOTHER'S MAIDEN NAME: Christiana Whittington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: Evelyn Lostie

ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of breast

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: November 30, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12-4-67

23C. NAME of CEMETERY or CREMATORY: Mt Calvary Cem

23D. LOCATION (City, town, or county) (State): Brooklyn Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Leroy A Wilson 2001 Brantley Rd

ADDRESS

VS 151-REV. 1/1/65

E-152

BIRTH NO. 66-00691 67 11688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11688

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANTHONY EVANS

2. DATE AND HOUR OF DEATH: 10:52 AM - 12-2-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 7-04
D. STREET ADDRESS (If rural, give location): 1808 ASHLAND AVE.

5. SEX: MALE
6. RACE: NEGROID
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: 1-15-66
9. AGE (In years last birthday): 1 YR
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baby
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HERMAN EVANS
14. MOTHER'S MAIDEN NAME: BERNICE Kentucu

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Bernice Pentecu
ADDRESS: Same

MEDICAL CERTIFICATION

✓ 1B. 571.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) gram negative sepsis — 4 hrs
DUE TO
(B) bacterial enteritis — 24 hrs
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.): —
21E. INJURY OCCURRED: While At Work ☐ Not ~~While~~ At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 12-2-67 19 to 12-2 1967, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William C. MacLean Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-2-67
23C. PHYSICIAN'S NAME (Type): WILLIAM C. MAC LEAN, JR. M.D.
23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-7-67
24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cut
24D. LOCATION (City, town, or county) (State): Brooklyn Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Tankey M.D.
25C. FUNERAL DIRECTOR: Clay Wilson
ADDRESS: 1001 Brantly St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

47-69-83 LB 1

m-200

BIRTH NO. 67 11689

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 11689

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): NELLIE MACK — NELLIE MACK

2. DATE AND HOUR OF DEATH: 12-4-67 — 12/4/67 — 5:45 PM — 5:45 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
31 BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: ANNE ARUNDEL — A.A.C.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): SEVERNA PARK. — 52-00
D. STREET ADDRESS (If rural, give location): BOX 262 RT. 1 21146

5. SEX: FEMALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SEPERATED
8. DATE OF BIRTH: 3-4-00
9. AGE (In years last birthday): 67
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Frank Sedgwick
14. MOTHER'S MAIDEN NAME: Elizabeth Maltey

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS: BALTIMORE CITY HOSPITALS
ADDRESS: 4940 EASTERN AVE., BALTO., MD. 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 156.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Liver failure — weeks
DUE TO
(B) Clear Cell Carcinoma of the Liver — 2 years
DUE TO
(C) Ec

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestive heart failure. — 2 weeks

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-2- 1967 to 12-4- 1967, that (I) (we) last saw the deceased alive on 12-4- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Terry E. Gagon M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/4/67
23C. PHYSICIAN'S NAME (Type): TERRY E. GAGON M.D.
23D. ADDRESS: RECORDS: BALTIMORE CITY HOSPITALS
4940 EASTERN AVE., BALTO., MD. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-8-67
24C. NAME of CEMETERY or CREMATORY: Holy Cross Cet
24D. LOCATION (City, town, or county) (State): Brooklyn Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: Clay Wilson
ADDRESS: 1000 Bentley

VS 150-REV. 1/1/65

M-67

67 11690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11690

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MORRIS, LETTIE (LOTTIE)

2. DATE AND HOUR OF DEATH: DECEMBER 3, 1967 10 30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 16-01

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 17

D. STREET ADDRESS (If rural, give location): 1221-W. Lafayette AVE

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH: 4/25/99

9. AGE (In years last birthday): 68

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New Port News Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jessie Anderson

14. MOTHER'S MAIDEN NAME: Sarah Harper

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hugh Taylor ADDRESS: 304 Poplar Terrace

MEDICAL CERTIFICATION

I

1B. 443X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO: Gangrene Small Bowel and CVA

(B) DUE TO: ASCHD & Hypertension

(C)

INTERVAL BETWEEN ONSET AND DEATH

4 days & 2 days (respectively)

12+ yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11/28, 11/29 12/2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Gangrene Small bowel, Resp. Insufficiency

20A. AUTOPSY? (Yes or No): YES.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from ~~Dec~~ Nov 28 1967 to DEC 3 1967, that ~~(I)~~ (we) last saw the deceased alive on Dec 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Arthur C. Burdett M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-3-67

23C. PHYSICIAN'S NAME (Type): Arthur C. Burdett M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-9-67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn

24D. LOCATION (City, town, or county): Catonsville (State): Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967

25B. NAME OF REGISTRAR: Robert E. Tankersley

25C. FUNERAL DIRECTOR: Floyd Wilson

ADDRESS: 1000 Brantly Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-540

BIRTH NO. 67 11691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11691

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH M. CONNOLLY

2. DATE AND HOUR OF DEATH: 12/4/67 9:30 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSP. 37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Harford Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~Baltimore~~ RURAL - FALLSTON
D. STREET ADDRESS (If rural, give location): 219A Mills Road

5. SEX: Male
6. RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 2/22/15
9. AGE (In years last birthday): 52
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10B. KIND OF BUSINESS OR INDUSTRY: FUNERAL HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Albert Connolly
14. MOTHER'S MAIDEN NAME: Mary Margaret Durley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-03-4400
17. INFORMANT: MRS. GLADYS CONNOLLY - SAME - ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — 18B. 155.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis
DUE TO
(B) ? primary (Liver)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH: mos. (approx.) J. M. Thorne

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/4 1967 to 12/4 1967. that (I) (we) last saw the deceased alive on 12/4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jean M. Thorne M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/4/67

23C. PHYSICIAN'S NAME (Type): JEAN M. THORNE M.D.
23D. ADDRESS: MERCY HOSPITAL - BALTO. MD.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/9/67
24C. NAME of CEMETERY or CREMATORY: PARKWOOD CEMETERY
24D. LOCATION (City, town, or county) (State): BALTIMORE Co. MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: LEONARD J. RUCK INC. ADDRESS: 6305 HARFORD RD #14

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

1

G-600 67 11692

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11692

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES L. GRAHE, Sr.

2. DATE AND HOUR PRONOUNCED DEAD: December 4, 1967 | 2:30 P. M.

CERTIFICATE AMENDED

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (FULL NAME OF HOSPITAL OR INSTITUTION, IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Johns Hopkins Hospital

12-12-67

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore #21234
D. STREET ADDRESS (If rural, give location): 4518 Kenwood Avenue

53-00

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	5-19-43	24				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fireman (Balto. City)		Maryland	U.S.A.

13. FATHER'S NAME: Edward J. Grahe, Jr.

14. MOTHER'S MAIDEN NAME: Ruth N. Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No-- Yes

16. SOCIAL SECURITY NO.: 213-42-3380

17. INFORMANT: Charlotte E. Grahe, ADDRESS: 4518 Kenwood Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E 924.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cranio-cerebral injury

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
12-3-1967	Brain Hemorrhage	Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. XXX

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Harford Rd. and North Avenue

9-08

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12/3/67 7:22 P. m.

21E. INJURY OCCURRED: WHILE AT WORK XXX ~~NOT WHILE AT WORK X~~

21F. HOW DID INJURY OCCUR? Firefighter thrown off firetruck

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 12/5/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12-8-67	Moreland Memorial	Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 6 1967	Robert E. Farley, M.D.	Leonard J. Ruck, Inc.,	5305 Harford Rd.

VS 151-REV. 1/1/65

N856.2

Letter from M.E.'s office 12-12-67 M.H.
and V.S. 153

BIRTH NO. C-636 67 11693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. X 67 11693

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CORDERY, FRANK C.

2. DATE AND HOUR OF DEATH: 12-5-67 11:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: BON SECOUR HOSP

(If not in hospital or institution, give street address or location): 2025 W FAYETTE ST Bal 21223 Md

34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: BALTIMORE CO.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21227 53-00

D. STREET ADDRESS (If rural, give location): 2413 BRUNSWICK Rd

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 12-23-92

9. AGE (In years last birthday): 74

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Gardner

10B. KIND OF BUSINESS OR INDUSTRY: Balto. City

11. BIRTHPLACE (State or foreign country): ENGLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Cordery

14. MOTHER'S MAIDEN NAME: Kate Dicks

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-30-5893

17. INFORMANT: Dorothy Cordery (wife)

ADDRESS: SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. I 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

congestive heart failure

(A) acute ~~pulmonary edema~~

DUE TO

(B) coronary insufficiency

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Perforated duodenal ulcer

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-4-67 19 to 12-5-67 11.30 a.m. 19, that (I) (we) last saw the deceased alive on 11.30 a.m 12-5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: M. Mohamadi M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12-5-67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: Bon Secours Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/8/67.

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.

ADDRESS: Balto. Md. 21214

RUCK

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

12-4-67
11.30 a.m 12-5 67

12-5-67 11.30 a.m.

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-300 67 11694

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11694

1. NAME OF DECEASED (Type or Print): Frieda A. Shade (Friedericka)

2. DATE AND HOUR OF DEATH: 12-5-67 | 1 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: 00
(If not in hospital or institution, give street address or location): 3103 Louise Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21214 27-05
D. STREET ADDRESS (If rural, give location): 3103 Louise Avenue

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: April 13, 1884.
9. AGE (In years last birthday): 83
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Koch
14. MOTHER'S MAIDEN NAME: Marie Dietzel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 217-09-0763-D
17. INFORMANT: Mrs. William Dobson
ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary insufficiency — 1 year
DUE TO
(B) Coronary arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 19 67 to Dec. 5 19 67, that (I) (we) last saw the deceased alive on April 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: R Donald Jandorf M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12-5-67
23C. PHYSICIAN'S NAME (Type): R Donald Jandorf M.D.
23D. ADDRESS: 6077 Harford Rd

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/8/67.
24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. C-155

M.E. CASE NO. 67 11695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11695

1. NAME OF DECEASED (Type or Print): ORISON G. CHAPMAN

2. DATE AND HOUR OF DEATH: 12/5/67 8 40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 12-03
D. STREET ADDRESS (If rural, give location): 2430 GREEN MOUNT AVE.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 12/23/08
9. AGE (In years last birthday): 58
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET-BARTENDER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): KENTUCKY
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph L. ~~LEMEN~~ CHAPMAN
14. MOTHER'S MAIDEN NAME: CORA SCOTT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 403-03-2496
17. INFORMANT: ZETTIE MRS. CHAPMAN
ADDRESS: SAME AS DECEASED

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart failure — 5 yrs
DUE TO
(B) Mitral insufficiency — 40 yrs
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

J. D. Mills

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 2 1967 to December 5 1967, that (I) (we) last saw the deceased alive on December 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Enrique Cipriani M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/5/67
23C. PHYSICIAN'S NAME (Type): ENRIQUE CIPRIANI MD. CIPRIANI M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/9/67
24C. NAME of CEMETERY or CREMATORY: MOUNTAIN VIEW MEM. GDNS
24D. LOCATION (City, town, or county) (State): HUDDY, KENTUCKY

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: LEONARD J. RUCK INC.
ADDRESS: 5305 HARFORD RD #14

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. G-320

M.E. CASE NO. 67 11696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11696

1. NAME OF DECEASED (Type or Print): Vincenzina Carmelia Gattuso

2. DATE AND HOUR OF DEATH: 12/4/67 11 25 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 5 — 702
D. STREET ADDRESS (If rural, give location): 2638 - McCleary St

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: 9/24/93
9. AGE (In years. If not birthday): 74
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph De Trapani
14. MOTHER'S MAIDEN NAME: Carmelia Tavolaci ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Antoinette Sanzone
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial infarction — 45 hours
DUE TO: + Cerebrovascular accident

(B)
DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/3 1967 to 12/4 1967, that (I) (we) last saw the deceased alive on 12/4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: G. Michael Vincent M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/4/67
23C. PHYSICIAN'S NAME (Type): G. MICHAEL VINCENT M.D.
23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/9/67.
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 6 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.
ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

H-208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11697 Registered No. 67 11697

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GEORGIANNA HOOKS (GEORGIANER)

2. DATE AND HOUR OF DEATH: 12-2-67 | 10 50 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSP. 48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 21229
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 20-06
D. STREET ADDRESS (If rural, give location): IN. BERNICE AVE

5. SEX: Female
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Separated
8. DATE OF BIRTH: 12-17-1913
9. AGE (In years last birthday): 53
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NURSES AIDE
10B. KIND OF BUSINESS OR INDUSTRY: HOSPITAL
11. BIRTHPLACE (State or foreign country): NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: COLUMBUS BATTLE
14. MOTHER'S MAIDEN NAME: MINNIE PROCTOR

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214 16 5379
17. INFORMANT: HOSPITAL CHART
ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 175.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Renal Failure
DUE TO
(B) Generalized CARCINOMATOSIS
DUE TO
(C) OVARIAN CARCINOMA - Metastatic

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 6-1-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Pelvic MASS
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-18 1967 to 12-2 1967, that (I) (we) last saw the deceased alive on 12-2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Maldonado M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-2-67
23C. PHYSICIAN'S NAME (Type): BENJAMINA MALDONADO M.D.
23D. ADDRESS: MD. GEN. HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-6-67
24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Pk.
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.
25B. NAME OF REGISTRAR
25C. FUNERAL DIRECTOR: Arlington A. Phillips
ADDRESS: 1729 N. Mond

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
H-400

67 11698

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11698

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN W. HAILEY Sr.

2. DATE AND HOUR PRONOUNCED DEAD: December 2, 1967 | 3:30 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Union Memorial Hospital D.O.A.

44/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-12
D. STREET ADDRESS (If rural, give location): 2314 Druid Park Dr.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored	Married	3-8-1911	56				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		North Carolina	

13. FATHER'S NAME: John Hailey

14. MOTHER'S MAIDEN NAME: Minnie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 242-07-3238

17. INFORMANT: Mary Hailey ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 591.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute fatty liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES	YES

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒, Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: December 2, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county)	(State)
Burial	12-3-67	Mt. Calvary	A.A. Co.	Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 6 1967	Robert E. Lafayette	Arlington A. Phillips	1727 McMoma St.

VS 151-REV. 1/1/65

K-530

BIRTH NO. 67 11699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11699

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LESTER Kennedy

2. DATE AND HOUR OF DEATH: 11/23/67 5:15 P.M. - M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1235 Wall St. #30

24-03

42

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	Caucasian	Married	12-2-04	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Minnesota

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

1B. 199.2 & 1581.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Adenocarcinoma — 4 1/2 mo.'s

DUE TO

(B) unknown Primary adenocarcinoma — ? months

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. chronic alcoholism; cirrhosis

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes) or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-9 19 67 to 11-23 19 67, that (I) (we) last saw the deceased alive on 11-23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Martin S. Liberman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 11-23-67

23C. PHYSICIAN'S NAME (Type): MARTIN S. LIBERMAN M.D.

23D. ADDRESS: Sinai Hospital of Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify):

24B. DATE: 11/30/67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR:

ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-624 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67-23612 67 11700 Registered No. 67 11700

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BABY BOY TROXELL

2. DATE AND HOUR OF DEATH: NOV. 24 '67 | 5:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSPITAL
35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 602
D. STREET ADDRESS (If rural, give location): 129 N. Montford Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	BABY	NOV. 23 '67			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not applicable
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY? AMERICAN

13. FATHER'S NAME: RAITHER TROXELL
14. MOTHER'S MAIDEN NAME: BLANCHE JANEK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): not applic.
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS. BLANCHE TROXELL ADDRESS: 129 N. Montford Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 773.5 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Resp. Hyaline Membrane Disease
DUE TO
(B) Prematurity
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: not applicable
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): not applicable
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): not applicable
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): not applicable

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): not applicable
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? not applicable

22. I certify that (I) (this hospital) attended the deceased from Nov. 23 19 67 to Nov. 24 19 67, that (I) (we) last saw the deceased alive on Nov. 23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Rodelio M. Lim M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 11-26-67
23C. PHYSICIAN'S NAME (Type): Rodelio M. Lim M.D.
23D. ADDRESS: CHH

24A. BURIAL CREMATION, REMOVAL (Specify):
24B. DATE: 11/28/67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD
ADDRESS:

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-45 1/2

BIRTH NO. 67-23098 67 11701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11701

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BABY GIRL B.G. Williams (A)

2. DATE AND HOUR OF DEATH: 11/18/67 | 1045 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 860 W. Fayette St

18-01

5. SEX: F
6. RACE: N
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 11/18/67
9. AGE (In years last birthday): If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 12 Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Balto.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: EMORY LEFTWICH
14. MOTHER'S MAIDEN NAME: MARGARET Williams

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. 776 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO: Immaturity

(B) DUE TO:

(C):

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/18 19 67 to 11/18 19 67, that (I) (we) last saw the deceased alive on 11/18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A Rosenstein M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 11/18/67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify):
24B. DATE: 11/28/67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State):

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
25B. NAME OF REGISTRAR: Robert E. Farber, M.D.
25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL
ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-4521

BIRTH NO. 67-23099 67 11702

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11702 V

1. NAME OF DECEASED (Type or Print): BABY BOY WILLIAMS B

2. DATE AND HOUR OF DEATH: 11-19-67 11:30 am M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY OF MARYLAND HOSPITAL

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

18-01

D. STREET ADDRESS (If rural, give location): 860 W. FAYETTE ST.

5. SEX: M

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED

8. DATE OF BIRTH: 11-18-67

9. AGE (In years last birthday): 0

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 23 Min.: 56

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: EMORY LEFTWICH

14. MOTHER'S MAIDEN NAME: MARGARET WILLIAMS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: HOSPITAL CHART

ADDRESS:

MEDICAL CERTIFICATION

18. 773.5 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) RESPIRATORY FAILURE

DUE TO

(B) PREMATURITY

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-18 19 67 to 11-19 19 67, that (I) (we) last saw the deceased alive on 11-19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Joyce M Boyd M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 11-19-67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): ANATOMY BOARD OF MARYLAND

24B. DATE: 11/28/67

24C. NAME of CEMETERY or CREMATORY: UNIVERSITY MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL

ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-200

BIRTH NO. 67-25151 67 11703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11703

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Baby Girl Byas

2. DATE AND HOUR OF DEATH: 11/20/67 12:04 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 Univ. of Md. Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto. City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1308 W. Lanvale St-17

16-02

5. SEX: F
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): never married
8. DATE OF BIRTH: 11/20/67
9. AGE (In years last birthday): If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours: 1 / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wherry Byas
14. MOTHER'S MAIDEN NAME: Annie Hicks

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Jane McCaffrey M.D. ADDRESS: Univ. of Md. Hosp.

MEDICAL CERTIFICATION

18. 776X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Immaturity

INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1:10 p.m. 11/20 19 67 to 2:04 p.m. 11/20 19 67, that (I) (we) last saw the deceased alive on 11/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jane E. McCaffrey M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 11/20/67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS: ANATOMY BOARD OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify)
24B. DATE: 11/28/67
24C. NAME of CEMETERY or CREMATORY: UNIVERSITY MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT. DEC 7 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-300

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67-26510 67 11704 Registered No. 67 11704

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BABY GIRL SCOTT

2. DATE AND HOUR OF DEATH: 12/2/67 | 10:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 16-04
D. STREET ADDRESS (If rural, give location): 924 Fulton Avenue

5. SEX: Female
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 12/2/67
9. AGE (In years last birthday): If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 10 Min.: 40

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: Shirley Scott

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. 773.5 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) REspiratory Distress — 10 hrs 40 min

DUE TO

(B) Prematurity — c

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from 12/2 1967 to 12/2 1967, that (I) (we) last saw the deceased alive on 12/2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: F S Reroma M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/2/67
23C. PHYSICIAN'S NAME (Type): F.S. Reroma M.D.
23D. ADDRESS: Lutheran Hospital of Maryland

24A. BURIAL CREMATION, REMOVAL (Specify):
24B. DATE: 12-4-67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR:
ADDRESS:

VS 150-REV. 1/1/65

R-1521

67 11705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67-24001

Registered No. 67 11705

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROBINSON BABY GIRL

2. DATE AND HOUR OF DEATH: 11/30/67 | 4:24 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hospital of Maryland Inc

46

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 16-06

D. STREET ADDRESS (If rural, give location): 1005 Poplar grove Street

5. SEX: F

6. RACE: N

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): —

8. DATE OF BIRTH: 11/30/67

9. AGE (In years last birthday): If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours: 3 Min.: 3

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Loucius

14. MOTHER'S MAIDEN NAME: Bordetta

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. 776X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Immaturity

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 3 hrs 3 min

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/30 1967 to 11/30 1967, that (I) (we) last saw the deceased alive on 11/30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S J Noble M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 11/30/67

23C. PHYSICIAN'S NAME (Type): S. J. NOBLE M.D.

23D. ADDRESS: LUTHERAN HOSPITAL 730 Lombard St

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE: 12-4-67

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR

ADDRESS

MORTUARY SERVICE - BCHD

ANATOMY BOARD OF MARYLAND

UNIVERSITY MEDICAL SCHOOL

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-140

BIRTH NO. 67 11706

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11706

1. NAME OF DECEASED (Type or Print): Herbert Joseph Covely Sr

2. DATE AND HOUR OF DEATH: 12-4-67 | 1215 p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 27-13

D. STREET ADDRESS (If rural, give location): 5704 Roland Ave.

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): SINGLE

8. DATE OF BIRTH: Feb 8-21

9. AGE (In years last birthday): 46.

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ROMAN CATHOLIC PRIEST (JESUIT)

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ALLENTOWN, PENNA

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: CLAUDE W. COVELY

14. MOTHER'S MAIDEN NAME: AGNES MELCHER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: REV. JUGH KENNEDY, S.J.

ADDRESS: 5704 ROLAND AVE

MEDICAL CERTIFICATION

18. 420.1 - 427X

CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Coronary occlusion	immediate
DUE TO	Myocardial degeneration	
(B)	Old infarction	one to two yrs
DUE TO		
(C)	Filiaradis	five years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?: —

22. I certify that (I) (~~this hospital~~) attended the deceased from SEPT. 13th 19 67 to Dec 4th 19 67, that (I) (~~we~~) last saw the deceased alive on Nov 27th 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (~~did~~) (~~did not~~) Did not view the body after death.

23A. SIGNATURE: Ray Lyman Sexton M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Dec 4th 67

23C. PHYSICIAN'S NAME (Type): Roy Lyman Sexton M.D.

23D. ADDRESS: 1801 Eye St. N. W. Wash. D.C. 20000

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/7/67

24C. NAME of CEMETERY or CREMATORY: JESUIT NOVITIATE CEMETERY, WERNERSVILLE, PENNA

24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: H. W. Meers & Son

ADDRESS: 805 N. Calvert St

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-256

BIRTH NO.

67 11707

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11707

1. NAME OF DECEASED (Type or Print): WM. P. WAGNER

2. DATE AND HOUR OF DEATH: 12-1-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 UNION MEM. HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 13-07

D. STREET ADDRESS (If rural, give location): 3712 CHESTNUT AVE.

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 8-23-08

9. AGE (In years last birthday): 59

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GROCER

10B. KIND OF BUSINESS OR INDUSTRY: SELF

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: DORIS L. WAGNER (SAME) ADDRESS:

MEDICAL CERTIFICATION

18. 420.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary Thrombosis

DUE TO

(B) Coronary Heart Disease

DUE TO

(C) Arteriosclerosis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1957 19 to 12/1/67 19, that (I) (we) last saw the deceased alive on 11/25/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Louis Vogel Jr. M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/4/67

23C. PHYSICIAN'S NAME (Type): DR. LOUIS VOGEL, JR. M.D.

23D. ADDRESS: 2601 E. Monument St. Balto-5 Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12-4-67

24C. NAME of CEMETERY or CREMATORY: MORELAND

24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Paul E. Chenowith Sr. ADDRESS: 3617 Chestnut Ave.

VS 150-REV. 1/1/65

1

5-520 67 11708

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11708

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HENRY M. SMICK

2. DATE AND HOUR PRONOUNCED DEAD: December 3, 1967 9:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 723 Gorsuch Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-05

D. STREET ADDRESS (If rural, give location): 723 Gorsuch Avenue

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 6-16-09

9. AGE (In years last birthday): 58

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BOOKEEPER

10B. KIND OF BUSINESS OR INDUSTRY: SELF

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): YES (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 213-09-9997

17. INFORMANT: ANNE W. SMICK ADDRESS: (SAME)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

443 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive and arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: December 4, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

23B. DATE: 12-7-67

23C. NAME of CEMETERY or CREMATORY: NATIONAL

23D. LOCATION (City, town, or county) (State): BALTO.

24A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967

24B. NAME OF REGISTRAR: Robert E. Lindsay

24C. FUNERAL DIRECTOR: Paul E. Chaconas Sr. ADDRESS: 3617 Gorsuch Ave.

VS 151-REV. 1/1/65

H-255T

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11709 Registered No. 67 11709

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): John P. Hickman

2. DATE AND HOUR OF DEATH: Dec. 2, 1967 Early P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 Sinai Hospital DOA 99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-16
D. STREET ADDRESS (If rural, give location): 2925 Edgecomb Cir.

5. SEX: M
6. RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: 5/13/23
9. AGE (In years last birthday): 44
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles A. Hickman
14. MOTHER'S MAIDEN NAME: Martha Amos

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Kathryn Barrett
ADDRESS: 2925 Edgecomb Cir.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 443X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) HeVD — 7 yr
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Psychoneurosis (apparently stable) — Several years

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from July 19 67 to 2 Dec 19 67, that (I) (~~we~~) last saw the deceased alive on Early Dec 1 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Jaroslav Hulla M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 5 Dec 67
23C. PHYSICIAN'S NAME (Type): Jaroslav Hulla M.D.
23D. ADDRESS: 2214 E. Fayette St. 21231

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/6/67
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: Witzke F. D. - 4101 Edmondson Av.
ADDRESS

VS 150-REV. 1/1/65

M-234

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11710

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11710

1. NAME OF DECEASED (Type or Print): Dorothy Alderson McDowall

2. DATE AND HOUR OF DEATH: December 3, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1801 Sherwood Avenue
Baltimore, Maryland 21214
00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1801 Sherwood Avenue 14

27-38

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: July 2, 1895
9. AGE (In years last birthday): 72
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Red Cross
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Alderson, W. Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John William Alderson
14. MOTHER'S MAIDEN NAME: Sara Garstang

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 219-10-6695
17. INFORMANT: Mrs. Sara M. Jarvis — ADDRESS: same address

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 416X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure — 15 yrs
DUE TO
(B) Rheumatic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 19 59 to December 19 67, that (I) (~~we~~) last saw the deceased alive on Nov 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Francis T. Daly M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/5/67
23C. PHYSICIAN'S NAME (Type): Dr. Francis T. Daly M.D.
23D. ADDRESS: 3201 N. Charles Street - 21218

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/4/67
24C. NAME of CEMETERY or CREMATORY: Old Greenbrien Baptish Cemetery
24D. LOCATION (City, town, or county) (State): Alderson, W. Va.

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
25B. NAME OF REGISTRAR: Robert E. Fowler, M.D.
25C. FUNERAL DIRECTOR: Wm. Tilmont Sons
ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

V-520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11711 Registered No. 67 11711

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ethel K. Vance

2. DATE AND HOUR OF DEATH: December 3, 1967 | 4 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3930 Belvieu Ave. Baltimore, Md. 21215

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3930 Belvieu Ave. 21215

15-10

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	December 25, 1883	83		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cinn. Ohio

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Edward C. Kimball

14. MOTHER'S MAIDEN NAME: Mary Taylor

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-32-6790

17. INFORMANT: Mr. Wm. Nickerson

ADDRESS: Sun Life Building Charles Center #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO: Arteriosclerotic Cardio

(B) DUE TO: Cerebro Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) Senility

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Senile Brain Syndrome

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 19 60 to December 3 19 47, that (I) (we) last saw the deceased alive on Dec 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: M Paul Beverly M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/4/67

23C. PHYSICIAN'S NAME (Type): M Paul Beverly M.D.

23D. ADDRESS: 5820 York Rd

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/6/67	Woodlawn Cemetery	Woodlawn, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 7 1967	B.O.H.S. [illegible]	Wm J. Tichnor Sons	Balto., Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-536

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11712 Registered No. 67 11712

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Elizabeth S. Henderson

2. DATE AND HOUR OF DEATH: December 2, 1967 | 8:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 2810 The Alameda Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 9-07
D. STREET ADDRESS (If rural, give location): 2810 The Alameda 21218

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Dec. 3, 1890
9. AGE (In years last birthday): 76
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George T. Savage
14. MOTHER'S MAIDEN NAME: Lucille Murphy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Walter S. Henderson
ADDRESS: same address

MEDICAL CERTIFICATION

18. 331 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebral Vascular Accid (Hemorrhage)
DUE TO
(B) Generalized arteriosclerosis
DUE TO
(C) Essential Hypertension

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
-

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from October 1963 to Dec 2 1967, that (I) (we) last saw the deceased alive on December 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Leonard Brill M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Dec. 4, 1967
23C. PHYSICIAN'S NAME (Type): Leonard Brill M.D.
23D. ADDRESS: 4130 Coleman Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/5/67
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Wm. J. Tichner & Sons
ADDRESS: Butler & North Ave.

VS 150-REV. 1/1/65

C-6201

67 11713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11713

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CROUSE, DANIEL EDWARD

2. DATE AND HOUR OF DEATH: DECEMBER 6, 1967 | 6:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND: ST AGNES HOSPITAL WILKENS AND CATON AVENUE BALTIMORE MARYLAND 21229

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21230 21-02
D. STREET ADDRESS (If rural, give location): 332 S POPPLETON STREET

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, ~~MARRIED~~ WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 03/20/01
9. AGE (In years last birthday): 66
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electric
10B. KIND OF BUSINESS OR INDUSTRY: Steel Co
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: JOSEPH Crouse
14. MOTHER'S MAIDEN NAME: BALDWIN, Mary

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 232 222459
17. INFORMANT: ST AGNES HOSPITAL WILKENS & CATON AVE.
ADDRESS:

MEDICAL CERTIFICATION

18. 177X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) TUMORAL CACHEXIA
DUE TO
(B) DISEMINATED METASTASIS
DUE TO
(C) ADENOCARCINOMA PROSTATE

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from DECEMBER 5, 1967 to DECEMBER 6 1967, that (X) (we) last saw the deceased alive on DECEMBER 6 1967 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.

23A. SIGNATURE: Alejandro Mejia
M.D. Attending Phys. ☐ Med. Director ☐ Staff Phy. X ☐
23B. DATE SIGNED: 12-6-67
23C. PHYSICIAN'S NAME (Type): ALEJANDRO MEJIA
23D. ADDRESS: M.D. ST AGNES HOSPTAL WILEKNS & CATON AVE.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/9/67
24C. NAME of CEMETERY or CREMATORY: McCoy Cemetery
24D. LOCATION (City, town, or county) (State): Webster Springs, W. Va

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
25B. NAME OF REGISTRAR: Robert E. Barkley M.D.
25C. FUNERAL DIRECTOR: John J. Cowan & Son Inc.
ADDRESS: 901 Hollins St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-635 1

67 11714 BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. Washington, D.C. **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. 67 11714

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) MICHAEL TRETTIN	2. DATE AND HOUR PRONOUNCED DEAD December 4, 1967 6:10 P. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 34 Bon Secours Hospital	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-31; D. STREET ADDRESS (If rural, give location): 620 Yale Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White		Dec. 12, 1965	1½		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Washington D. C.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Vernon W. Trettin	Shirley L. Locke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Balto. Md.	
		Mrs. Shirley L. Trettin	620 Yale Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) E900.0

(A) Epidural Hematoma

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	home	620 Yale Avenue 25-31

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
11/30/67 7:10 P. m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	at top of cellar stairs fell under handrail to the concrete floor

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE [signature] M.D.

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED 12/5/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	Dec. 6, 1967	Glen Haven Cem.	Glen Burnie, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 7 1967	Robert E. Fackenthal	G. Truman Schwab	3512 Frederick Ave. Balto. Md.

VS 151-REV. 1/1/65

N854.2

6-000

67 11715 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11715

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LINWOOD LEE

2. DATE AND HOUR PRONOUNCED DEAD: December 3, 1967 | 10:00 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 4800 block of Old York Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-10
D. STREET ADDRESS (If rural, give location): 602 Richwood St.

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 7/24/16
9. AGE (In years last birthday): 51
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10B. KIND OF BUSINESS OR INDUSTRY: CONTRACTOR
11. BIRTHPLACE (State or foreign country): U.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MATHEW LEE
14. MOTHER'S MAIDEN NAME: MAUDE BROWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 229-16-8976
17. INFORMANT: Dorothy LEE
ADDRESS: 602 Richwood ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E 891.5

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia
DUE TO
Carbon Monoxide Poisoning

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 4800 block Old York Rd. 27-11

21D. TIME OF INJURY (APPROX.) (Month) 12 (Day) 2-3 (Year) 67 (Hour) ? m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Subject found in parked car

22. I certify that I held on Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE Edward F. Wilson M.D.
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED December 3, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12/9/67
23C. NAME of CEMETERY or CREMATORY: Mt. Tabor
23D. LOCATION (City, town, or county) (State): Shrimanville, Va.

24A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Wm. S. Chatman Jr.
ADDRESS: 1701 McCulloh St. Balto. Md.

VS 151-REV. 1/1/65

N968.0

1
J-100

67 11716 BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11716

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EDITH JEFFO

2. DATE AND HOUR PRONOUNCED DEAD: November 30, 1967 | 7:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-05
D. STREET ADDRESS (If rural, give location): 1719 North Calvert Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Divorce	Jan 1, 1927	40				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	—	Danville VA.	U.S.A.

13. FATHER'S NAME: E. A. Harville

14. MOTHER'S MAIDEN NAME: Louella Holder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

16. SOCIAL SECURITY NO.

17. INFORMANT: Geo. Harvell ADDRESS: 21205 11xx Newcombe Way

MEDICAL CERTIFICATION

18. E 812.4

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia complicating multiple traumatic injuries

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
11-13-67	Vein Injury	Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Route 40 and Ebenezer Road = Baltimore County 53-00

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 11-12-67 11:15 P.m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Charles S. Springate M.D. — Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: November 30, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/2/67	Highland Burial Pk.	Danville, Virginia

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 7 1967	Robert E. Fahrenna	Joseph R. Zannino	243 S Conkling

VS 151-REV. 4/4/65

N 869.2

M-240

BIRTH NO. 67 11717

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11717

1. NAME OF DECEASED (Type or Print): MR. PETER MICELI

2. DATE AND HOUR OF DEATH: 11-29-67 | 3:46 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL 33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: Balto C

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 1960 WOODLAWN DRIVE

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 11-12-20

9. AGE (In years last birthday): 47

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BRANCH MANAGER

10B. KIND OF BUSINESS OR INDUSTRY: GENERAL CIGAR

11. BIRTHPLACE (State or foreign country): BALTIMORE

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SANTO MICELI

14. MOTHER'S MAIDEN NAME: FANNIE D'ANNA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): WWII + KOREAN - ARMY

16. SOCIAL SECURITY NO.: 214-03-0931

17. INFORMANT | ADDRESS

MEDICAL CERTIFICATION

1B. 200.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) Reticulum Cell Sarcoma — 2 yrs +

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-1 19 67 to 11-29 19 67, that (I) (we) last saw the deceased alive on 11-29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert A Cordes M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 11-29-67

23C. PHYSICIAN'S NAME (Type): ROBERT A. CORDES M.D.

23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/4/67

24C. NAME of CEMETERY or CREMATORY: Woodlawn

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967

25B. NAME OF REGISTRAR: Robert E. Farley

25C. FUNERAL DIRECTOR: Joseph N. Zarrico

ADDRESS: 263 S Conkling

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
H-300

67 11718 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11718

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WALTER S. HITE

2. DATE AND HOUR PRONOUNCED DEAD: December 4, 1967 8:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1416 W. Pratt Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1903
D. STREET ADDRESS (If rural, give location): 1416 W. Pratt Street

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: March 25, 1903.
9. AGE (In years last birthday): 64 XXX
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Window cleaner
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: L. F. Hite
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 228-03-6633
17. INFORMANT: Landrum D. Hite
ADDRESS: 9021 Carlisle Avenue Balto., Md. 21236

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: December 4, 1967

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial
23B. DATE: Dec. 7, 1967
23C. NAME of CEMETERY or CREMATORY: Cedar Hill Cemetery
23D. LOCATION (City, town, or county) (State): Anne Arundel Co. Maryland

24A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Walters Funeral Home
ADDRESS: Pratt & Stricker Sts.

VS 151-REV. 1/1/65

1
B-200

67 11719 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11719

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BESSIE S. NICHOLS Buck

2. DATE AND HOUR PRONOUNCED DEAD: December 5, 1967 10:12 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 2245 E. Fayette St.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

6-03

D. STREET ADDRESS (If rural, give location): 2245 E. Fayette Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Unknown	8-18-1915	52				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Attentant		Reedy, West Virginia	U.S.A

13. FATHER'S NAME: James Nichols

14. MOTHER'S MAIDEN NAME: Sarah Callow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Vandale Funeral Home, Spencer, West Va. ADDRESS

MEDICAL CERTIFICATION

1B. 600.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) ~~XXXXX~~ Acute Suppurative Peritonitis due to perinephric abscess

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Partial

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

2

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy Partial ☐ and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 12/5/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12-9-1967	Fairview Cemetery	Reedy, West Virginia

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 7 1967	Robert E. Farley, M.D.	Howard H. Hubbard	4107 Wilkens Ave. 21229

VS 151-REV. 1/1/65

1
W-420

67 11720

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11720

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAKE N. WELLS

2. DATE AND HOUR PRONOUNCED DEAD: December 5, 1967 | 10:25 PM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 234 No. Amity St.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-01

D. STREET ADDRESS (If rural, give location): 234 No. Amity St.

5. SEX: Male

6. RACE: Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: July 21, 1899

9. AGE (In years last birthday): 68

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer- retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Sumpter S.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wells

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-10-1972

17. INFORMANT: Hattie Wells

ADDRESS: 234 N. Amity St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: December 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: Dec. 9, 1967

23C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Park

23D. LOCATION (City, town, or county): Arbutus (State): Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Williams Funeral Home

ADDRESS: 3199 N. Schroeder St.

VS 151-REV. 1/1/65

1

M-56067 11721

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11721

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EDWIN S. MONROE

2. DATE AND HOUR PRONOUNCED DEAD: December 5, 1967 | 2:43 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 5300 Eastbury Ave. Apt. E.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-02

D. STREET ADDRESS (If rural, give location): 5300 Eastbury Ave. Apt. E.

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced

8. DATE OF BIRTH: 12-18-1915

9. AGE (In years last birthday): 51

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10B. KIND OF BUSINESS OR INDUSTRY: Bakery

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John H Monroe

14. MOTHER'S MAIDEN NAME: Ida Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: John Monroe

ADDRESS: Oneida Pl NW DC

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 581.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fatty Liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: YES

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12.9.1967

23C. NAME of CEMETERY or CREMATORY: Hillsboro

23D. LOCATION (City, town, or county): Hillsboro (State): Va.

24A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967

24B. NAME OF REGISTRAR: Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR: G. Howard Strong

ADDRESS: 3207 W. North Ave.

VS 151-REV. 1/1/65

SAB-50-55-001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B-6J 0 67 11722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11722

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Robert Brown

2. DATE AND HOUR OF DEATH: 12/6/67 | 8^10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 14-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2037 McCulloh Street 21217

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	Widowed	2-4-85	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert

14. MOTHER'S MAIDEN NAME: Martha

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-01-8915

17. INFORMANT: Records: BCH-4940 Eastern Avenue 2124 — M. Cross 4819 Palmer Ave (Daughter)

MEDICAL CERTIFICATION

1B. 177X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~Uremia~~ Carcinoma of Prostate

DUE TO

(B) Uremia

DUE TO

(C) Renal Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: 11-13-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Prostate CA - needle biopsy

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 12/1/67 19 to 12/6/67 19, that (I) (we) last saw the deceased alive on 12/6/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: B. D. Richman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/6/67

23C. PHYSICIAN'S NAME (Type): B. D. Richman M.D.

23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/9/67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Pk.

24D. LOCATION (City, town, or county) (State): Arbutus, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: Kelson Funeral Home

ADDRESS: 1348 Calhoun St.

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B-650 67 11723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11723

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MINNIE GERTRUDE BROWN

2. DATE AND HOUR OF DEATH: DECEMBER 4,1967 | 3 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: 00
(If not in hospital or institution, give street address or location): 1537 North Wolfe Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21213 8-06
D. STREET ADDRESS (If rural, give location): 1537 North Wolfe Street

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: May 5,1914
9. AGE (In years last birthday): 53
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Smith
14. MOTHER'S MAIDEN NAME: Minnie Hurt

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214 20 4335
17. INFORMANT: Mr Lawrence H. Brown SR.
ADDRESS: 1537 North Wolfe Street

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 163X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Malignancy of lungs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Jan 1960 to 12/4 1967, that (I) (~~we~~) last saw the deceased alive on 12/2 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Joseph R. Liberto M.D. Attending Phys. [X] Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/5/67
23C. PHYSICIAN'S NAME (Type): Joseph R. Liberto M.D.
23D. ADDRESS: 3508 Bank Street

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/7/67
24C. NAME of ~~CEMETERY~~ or CREMATORY: BALTIMORE CEMETERY
24D. LOCATION (City, town, or county) (State): BALTIMORE MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: HENRY SANDER & SONS INC.
ADDRESS: BALTIMORE MARYLAND 21213

VS 150-REV. 1/1/65

48-71-72 GG 1

E 300

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11724 Registered No. 67 11724

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MAGGIE SCOTT

2. DATE AND HOUR OF DEATH: 12-5-67 4.30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND
31 BALTIMORE CITY HOSPITALS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 25-32
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 928 CHERRY HILL ROAD 21225

5. SEX: FEMALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 3-15-89
9. AGE (In years last birthday): 78
If Under 1 Yr. Months: 8 Days: Hours: If Under 24 Hrs. Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: RANDOLPH
14. MOTHER'S MAIDEN NAME: MAGGIE GRAY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 820-00-7658
17. INFORMANT: RECORDS: BCH 4940 EASTERN AVE. BALTO. MD. 21224.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
1B. 443 X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CACHECTIC STATE — 7 months
DUE TO
(B) CHRONIC BRAIN SYNDROME — 3 years
DUE TO
(C) HASCVD — PARKINSON'S DIS — 3 years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/16 19 67 to 12/5 19 67, that (I) (we) last saw the deceased alive on 12/5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: G. ALARCON M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/5/67
23C. PHYSICIAN'S NAME (Type): DR. GRACIELA ALARCON GRACIELA ALARCON M.D.
23D. ADDRESS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-9-67
24C. NAME of CEMETERY or CREMATORY: Ind. Auburn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Charles A. Rice, ADDRESS: 661 W. Barre St

VS 150-REV. 1/1/65

M. 2001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11725 Registered No. 67 11725

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): John Mack

2. DATE AND HOUR OF DEATH: 12-3-67 4:30 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Bukeland Nursing Home 1501 N. Bukeland St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 12-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 313 E. North Ave.

5. SEX: M
6. RACE: N
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 8/26/90
9. AGE (In years last birthday): 77.
If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME: Soloman Hall
14. MOTHER'S MAIDEN NAME: Frances

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Nathaniel Mack ADDRESS: 1330 W Lafayette

MEDICAL CERTIFICATION

18. 7 22.1 I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL THROMBOSIS — 3 DAYS

DUE TO

(B) ARTERIOSCLEROTIC CARDIC VASCULAR DISEASE — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-24 1967 to 12-3 1967, that (I) (we) last saw the deceased alive on 12-3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Thomas W. Harris M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12-4-67
23C. PHYSICIAN'S NAME (Type): THOMAS W. HARRIS M.D.
23D. ADDRESS: 1824 W. FRANKLIN ST

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/6/67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Charles A Rice
ADDRESS: 661 W Barre

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-0001

25

67 11726

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11726

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DR. HENRY W. SCHEYE

2. DATE AND HOUR PRONOUNCED DEAD: December 5, 1967 | 5:50 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 48 Maryland General Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 845 Hill Top Road

53-00 #28

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	Jan. 8, 1914	53				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Physician		Germany	

13. FATHER'S NAME: Ernest Scheye

14. MOTHER'S MAIDEN NAME: Sophie Freund

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-46-5841

17. INFORMANT: Mrs. Henry Scheye — ADDRESS: 845 Hilltop Rd. - Catonsville, Md.

MEDICAL CERTIFICATION

18. 443 X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive and Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection [X] Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes [XX] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R Fisher M.D.

CHIEF MEDICAL EXAMINER [X]
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): RUSSELL S. FISHER, M.D.

DATE SIGNED: December 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/7/67	Baltimore Hebrew Cem.	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 7 1967	Robert E. Farley M.D.	Witzke F. D.	4101 Edmondson Ave.

VS 151-REV. 1/1/65

S.335 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11727 Registered No. 67 11727

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Kathryn A. Stidman

2. DATE AND HOUR OF DEATH: Dec. 5, 1967 | 6:00 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street oddress or location): 00 5513 The Alameda

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 27-38

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 5513 The Alameda

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	Widowed	July 10, 1881	86		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Carroll Co., Md.	U.S.A.

13. FATHER'S NAME: Tobias C. Stocksdale

14. MOTHER'S MAIDEN NAME: Clara Belle Horner

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		219-22-2367-D	Mrs. Grace V. Hoppert	(Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 18. 450.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis, generalized; stroke (1960) (?)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		no	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov 24 1967 to Dec 5 1967, that (I) (we) last saw the deceased alive on Nov 28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: N B Herman M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Dec 5, 1967

23C. PHYSICIAN'S NAME (Type): N. B. Herman M.D.

23D. ADDRESS: 5510 Roland Ave. Baltimore, Md. 21210

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	12/8/67	Zion Church	Finksburg,	Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 7 1967	Robert E. Farkyne	H. W. Jenkins & Sons Co.	4905 York Road Baltimore, Md. 21212

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-520 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11728

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lillian Latherow Reams

2. DATE AND HOUR OF DEATH: 12-4-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Haven Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Chester
D. STREET ADDRESS (If rural, give location): 805 E 22nd St

V-35

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 10-7-1876
9. AGE (In years last birthday): 91
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Latherow
14. MOTHER'S MAIDEN NAME: Fraker

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Kenneth G Ellison
ADDRESS: 14981 Flanders Detroit Michigan 48205

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

18. 450.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Infarction of Age
DUE TO
(B) Generalized Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept 1967 to Dec 1967, that (I) (we) last saw the deceased alive on ____ 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W Thos G Abbott M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12-5-67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-6-67
24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner M.D.
25C. FUNERAL DIRECTOR: Elsworth Armacost
ADDRESS: 4600 Liberty Rd

VS 150-REV. 1/1/65

S-240

BIRTH NO.

M.E. CASE NO.

67 11729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11729

1. NAME OF DECEASED (Type or Print): Siegle, Mary ~~Mrs.~~

2. DATE AND HOUR OF DEATH: 12-6-1967 | 9:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MONTEBELLO STATE HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 3718 Monterey Road

9-03

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	Widow	10-26-1883	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Rietdorf

14. MOTHER'S MAIDEN NAME: Kate McCullough

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-52-2282

17. INFORMANT: John W. Seigle ADDRESS: 3718 Monterey Rd. 21218

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonitis, Reccurent

DUE TO

(B) A.S.C.V.D with C.H.F.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-12- 1965 to 12-6- 1967, that (I) (we) last saw the deceased alive on 12-6- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Young Hea Lew M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-6-1967

23C. PHYSICIAN'S NAME (Type): YOUNG HEA LEW M.D.

23D. ADDRESS: Montebello State Hosp. Balt, MD

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/9/67v

24C. NAME of CEMETERY or CREMATORY: Baltimore Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks, Inc. ADDRESS: 1217 St. Paul St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-160

BIRTH NO. 67 11730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11730

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FRANK N. PIEPER

2. DATE AND HOUR OF DEATH: December 6, 1967 | 2 30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1738 Carswell St.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

9-07

D. STREET ADDRESS (If rural, give location): 1738 Carswell St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Widowed	2/27/81	86				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Lithographer	Printing	Maryland	USA

13. FATHER'S NAME: August Pieper

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214 01 4164

17. INFORMANT: Mr. John Pieper- 6001 Sycamore Rd.

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. 331X & 177X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4-5 days

DUE TO

(B) arteriosclerosis

DUE TO

(C) senility

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma prostate

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this ~~hospital~~) attended the deceased from 1955 to Dec 6 1967, that (I) (~~we~~) last saw the deceased alive on Dec 5 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Theodore J. Graziano M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): Dr. Theodore J. Graziano M.D.

23D. ADDRESS: 2802 Harford Rd., Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/9/67	Moreland Cemetery	Baltimore Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc. ADDRESS: 5305 Harford Rd. #14

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. T-622 67 11731

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11731

1. NAME OF DECEASED (Type or Print): Nancy Lou Trageser

2. DATE AND HOUR OF DEATH: 12-5-67 11:40 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21218
D. STREET ADDRESS (If rural, give location): 3212 Calvert St

12-02

5. SEX: Female
6. RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married
8. DATE OF BIRTH: 3-24-1890
9. AGE (In years last birthday): 77
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? Jones
14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 214-14-8598
17. INFORMANT: Mr. Richard J. Trageser
ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease
DUE TO
(B) acute myocardial infarction — 4-6 hours
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 12-5-67 8:55 PM 19 67 to 12-5-67 11:40 PM 19 67, that (I) (we) last saw the deceased alive on 12-5 19 67 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) ~~did~~ (~~did not~~) view the body after death.

23A. SIGNATURE: Joe T Chandler M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-5-67
23C. PHYSICIAN'S NAME (Type): JOE T. CHANDLER M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Entombment
24B. DATE: 12/8/67.
24C. NAME of CEMETERY or CREMATORY: Lorraine Park Mausoleum
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.
ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

1

B-650

BIRTH NO. 67 11732

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11732

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Elizabeth V. Brown

2. DATE AND HOUR OF DEATH: Dec. 6, 1967 | 5:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1506 Pentridge Rd.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21212

27-09

D. STREET ADDRESS (If rural, give location): 1506 Pentridge Rd

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: Sept. 12, 1877.

9. AGE (In years last birthday): 90

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired School Teacher

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Brown

14. MOTHER'S MAIDEN NAME: Edwardean Wayson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-44-2337

17. INFORMANT: Miss Mabel Brown

ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

420.1

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1965 to 12 - 6 1967, that (I) (~~we~~) last saw the deceased alive on 12 - 5 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: William P Benson Jr. M.D. — Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-7-67

23C. PHYSICIAN'S NAME (Type): William Benson M.D.

23D. ADDRESS: 3506 N Calvert St Baltimore, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/9/67.

24C. NAME of CEMETERY or CREMATORY: Baltimore Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967

25B. NAME OF REGISTRAR: Robert E. Tankey M.D.

25C. FUNERAL DIRECTOR: Leonard J Ruck Inc.

ADDRESS: 5305 Harford Rd

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-532

BIRTH NO. 67 11733

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 392716. 67 11733

1. NAME OF DECEASED (Type or Print): JOHN H. LINDSAY

2. DATE AND HOUR OF DEATH: 12/6/1967 | 8.10 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 Sinai Hospital of Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland. B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore.

9-02

D. STREET ADDRESS (If rural, give location): 3533 Alameda ~~xxx~~ Circle

5. SEX: M

6. RACE: W.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 10/16/1894

9. AGE (In years last birthday): 73

If Under 1 Yr.: Months | Days

If Under 24 Hrs.: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Engineer

10B. KIND OF BUSINESS OR INDUSTRY: B&O R R

11. BIRTHPLACE (State or foreign country): Ill.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John O Lindsay

14. MOTHER'S MAIDEN NAME: Laura Hill

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): W W 1

16. SOCIAL SECURITY NO.: 705-07-9377

17. INFORMANT: Martha J Lindsay ~~xxxxxxxxxxxxxxxxxxxxxxxxxxxx~~ ADDRESS: Same

18. 161X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CA. Larynx with

DUE TO

(B) obstruction to air way

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

3

19A. DATE OF OPERATION: 12/2/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: of lungs for ventilation

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/2 1967 to 12/6 1967, that ~~(I)~~ (we) last saw the deceased alive on 12/6 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/6/67

23C. PHYSICIAN'S NAME (Type): D. J. PRADHAN M.D.

23D. ADDRESS: SINAI HOSPITAL OF BALTIMORE

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/11/67

24C. NAME of CEMETERY or CREMATORY: Baltimore National

24D. LOCATION (City, town, or county) (State): Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967

25B. NAME OF REGISTRAR: Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR: Leonard J Ruck Inc. ADDRESS: 5305 Harford Rd

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B-530

BALTIMORE CITY HEALTH DEPARTMENT

67 11734 **CERTIFICATE OF DEATH**

Registered No. 67 11734

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Percy Bennett

2. DATE AND HOUR OF DEATH: 2 30 PM 12-5-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: Baltimore, Md.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 11-02
D. STREET ADDRESS (If rural, give location): 814 St. Paul St.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 6-11-07
9. AGE (In years last birthday): 60
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ky.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: John Bennett
14. MOTHER'S MAIDEN NAME: Ethel Hunter

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): U
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 432-07-4535
17. INFORMANT: Griffin-Leggett F. H.
ADDRESS: Little Rock, Ark. 1000 W. Capital Av.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 540 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: unk.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12-2-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Perforated Stomach Ulcer
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-2 1967 to 12-5 1967, that (I) (we) last saw the deceased alive on 12-5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Eldon L. Hawbaker M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-5-67
23C. PHYSICIAN'S NAME (Type): Eldon L. Hawbaker M.D.
23D. ADDRESS: Mercy Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/8/67
24C. NAME of CEMETERY or CREMATORY: Rest Hills, Cem.
24D. LOCATION (City, town, or county) (State): Little Rock, Ark.

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Wm. Cook-Brooks, Inc.
ADDRESS: 1217 St. Paul St.

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M-263

BALTIMORE CITY HEALTH DEPARTMENT

67 11735 **CERTIFICATE OF DEATH** Registered No. 67 11735

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MCGRATH ELISABETH

2. DATE AND HOUR OF DEATH: 12-6-67 | 1:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 UNION MEMORIAL HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 13-01
D. STREET ADDRESS (If rural, give location): 2601 MADISON AVE.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: 7-17-96
9. AGE (In years last birthday): 71
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ABRAHAM B. CLINE
14. MOTHER'S MAIDEN NAME: ELIZABETH T. JONES

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): ?
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-03-6796
17. INFORMANT: JOHN MCGRATH Jr. ADDRESS: 8 ORKNEY COURT #12

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 153.8

(A) METASTATIC Ca of Colon — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B) C.H.F.
DUE TO
(C) AURICULAR Fib.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 10-24-67, 11-10-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca of Colon
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-18 19 67 to 12-6 19 67, that (I) (we) last saw the deceased alive on 12-6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Frank Palmisano M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12-6-67
23C. PHYSICIAN'S NAME (Type): FRANK S. PALMISANO JR. M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 12/7/67
24C. NAME of CEMETERY or CREMATORY: Greenmount Crematory
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Wm. Cook-Brooks, Inc. ADDRESS: 1217 St. Paul St.

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. N-260 67 11736

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11736

1. NAME OF DECEASED (Type or Print): ALBERT NASSAR

2. DATE AND HOUR OF DEATH: 12-7 67 | 0²⁰ A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-05

D. STREET ADDRESS (If rural, give location): 29 E North Ave.

48

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced

8. DATE OF BIRTH: 12-20 '10

9. AGE (In years last birthday): 56

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?

10B. KIND OF BUSINESS OR INDUSTRY: ?

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: Elias Nasser

14. MOTHER'S MAIDEN NAME: Mary Abraham

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNK. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: MOSKAL F. H. ADDRESS: JOHNSTOWN, PA

MEDICAL CERTIFICATION

I

1B. 420.1 + 260X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Acute myocardial infarction

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 15 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus
Obesity

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-28 1967 to 12-7 1967, that (I) (we) last saw the deceased alive on 12-6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fridtjofur Bjornsson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12-7 67

23C. PHYSICIAN'S NAME (Type): FRIDTJOFUR BJORNSSON M.D.

23D. ADDRESS: Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/11/67

24C. NAME of CEMETERY or CREMATORY: Headricks Cem.

24D. LOCATION (City, town, or county) (State): Johnstown, Pa.

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Wm. Cook Brooks Inc. ADDRESS: 1217 St Paul St.

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. M-624 67 11737 Registered No. 67 11737

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Merkel, Dora

2. DATE AND HOUR OF DEATH: 12/4/67 16 45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY: 27-17 C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 5400 Clover Road

5. SEX: F 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): W 8. DATE OF BIRTH: 01/17/98 9. AGE (In years last birthday): 69 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 10B. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): ? Maryland 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Abraham Friedman 14. MOTHER'S MAIDEN NAME: Sophie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): 16. SOCIAL SECURITY NO.: 215 09 9824 17. INFORMANT: Samuel Merkel ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 331 X

(A) Cerebral Vascular Accident

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/02/1967 to 12/4/1967, that (I) (we) last saw the deceased alive on 12/4/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: H. F. Holcomb M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 12/4/67

23C. PHYSICIAN'S NAME (Type): H. F. HOLCOMB, M.D. 23D. ADDRESS: UNION MEMORIAL HOSPITAL Union Memorial Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial 24B. DATE: 12/6/67 24C. NAME of CEMETERY or CREMATORY: Har Zion Israelite Israel 24D. LOCATION (City, town, or county): Balto (State): Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967 25B. NAME OF REGISTRAR: Robert E. Farley, M.D. 25C. FUNERAL DIRECTOR: Sylvan S. Levin & Son Inc ADDRESS: Garrison Md

VS 150-REV. 1/1/65

M-625

BIRTH NO. 67 11738

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11738

1. NAME OF DECEASED (Type or Print): Harold E. Morgan

2. DATE AND HOUR OF DEATH: Dec. 4 1967 | 1:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: SULPHUR
1413 Sulphur Spring Rd. Baltimore Md.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Balto Co.
D. STREET ADDRESS (If rural, give location): ~~Aug 21 1902~~ 53.00

5. SEX: M.
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Aug. 21 1902
9. AGE (In years last birthday): 65
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Automobile service
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Louisiana
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Jesse Morgan
14. MOTHER'S MAIDEN NAME: Mollie Nesbitt

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W. W. II
16. SOCIAL SECURITY NO.: 215 01 8126
17. INFORMANT: Anna Morgan
ADDRESS: 1413 Sulphur Spring Rd 21227

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ruptured Aneurysm of aorta — INTERVAL BETWEEN ONSET AND DEATH: One day
DUE TO
(B) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: Several yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 8 1965 19 to Dec. 4 1967, that (I) (we) last saw the deceased alive on Dec. 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S. J. Lin M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Dec. 4 1967
23C. PHYSICIAN'S NAME (Type): S. J. Lin M.D.
23D. ADDRESS: 5301 Harford Road Baltimore Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/8/67
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 7 1967
25B. NAME OF REGISTRAR: Robert E. Tarkington
25C. FUNERAL DIRECTOR: Ambulance Inc. 1328 Sulphur Spring Rd.
ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-300

BIRTH NO.

M.E. CASE NO. Everett

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11739

1. NAME OF DECEASED (Type or Print) Edward R. White

2. DATE AND HOUR OF DEATH 12/6/67 9:00 PM. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Century Home Inc 102 N. Paca St 21201

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY 864 W. Baltimore St

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 18-01

D. STREET ADDRESS (If rural, give location) 864 W. Baltimore St.

5. SEX	6. RACE	7. MARITAL STATUS	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	Hours	Min.
M	W	Never Married	12/9/90	76				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Watchman	United Fruit	Salisbury, Md.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Sidney White	Emily V. Brewington

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		215-05-8231 A.	Mrs. Ella V. Harle	121 E. West St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1

(A) Cardio Respiratory Failure

DUE TO Massive Hyperdiastolic Distention

(B) Arteriosclerotic CVHD

DUE TO Gen. Arteriosclerosis

(C) Chronic Brain Syndrome

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DEC 10 1963 to DEC 6 1967, that (I) (we) last saw the deceased alive on DEC 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE Willard Appleford M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ — 23B. DATE SIGNED 12/7/67

23C. PHYSICIAN'S NAME (Type) WILLARD APPLEFORD MD M.D. — 23D. ADDRESS 5901 Park Heights Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12-8-67	Parsons Cemetery	Salisbury, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 7 1967	Robert E. Farley, MD	Flynn & Fleming	1422 Light St. Balto. Md.

VS 150-REV. 1/1/65

K-325

67 11740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11740

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ernest KATZENSTEIN

2. DATE AND HOUR OF DEATH: Dec 6/67 | 8:30A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Balto, MD. B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 53-00

D. STREET ADDRESS (If rural, give location): 8402 SIGRID ROAD

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 3/19/1917

9. AGE (In years last birthday): 50

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MANAGER

10B. KIND OF BUSINESS OR INDUSTRY: INS.

11. BIRTHPLACE (State or foreign country): GERMANY

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Solomon

14. MOTHER'S MAIDEN NAME: ROSE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 212-16-3883

17. INFORMANT: WIFE

ADDRESS: SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

I 1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO: Myocardial infarction - acute — INTERVAL BETWEEN ONSET AND DEATH: 8:00-8:30AM

(B) DUE TO: Pulmonary embolism and thrombosis - 8 weeks

(C): ASCVD - 20 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/2/67 19 67 to Dec 6 19 67, that (I) (we) last saw the deceased alive on 8:30AM 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A S Glushakow M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Dec 6-1967

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/8/1967

24C. NAME of CEMETERY or CREMATORY: Har Sinai

24D. LOCATION (City, town, or county) (State): Owings Mills Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Sylvan S. Levin & Son, Inc

ADDRESS: Garrison Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

2-532

126 14 58 R
ZENTGRAF, HENRY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

67 11741

Registered No. 67 11741

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ZENTGRAF, HENRY

2. DATE AND HOUR OF DEATH: DEC 4th, 1967 9:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 803 BRUNSWICK ROAD

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 8-14-87

9. AGE (In years last birthday): 80

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LARRY ZENTGRAF

14. MOTHER'S MAIDEN NAME: MARY WEIDER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNK (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-12-0670

17. INFORMANT: JOHNS HOPKINS RECORDS ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ASCVD

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/30 1967 to 12/4 1967, that (I) (we) last saw the deceased alive on 12/4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jack Brandes M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/4/67

23C. PHYSICIAN'S NAME (Type): JACK BRANDES M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/6/67

24C. NAME of CEMETERY or CREMATORY: PARKWOOD CEM.

24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: J. G. CONNELLY

ADDRESS: 300 MACE

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-242

BIRTH NO. 67 11742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11742

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Eugene McLaughlin

2. DATE AND HOUR OF DEATH: 12/6/67 | 2 50 M.

CERTIFICATE AMENDED 12-20-67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Towson
D. STREET ADDRESS (If rural, give location): 8025 RIDER AVE.

53-00

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	M	10/11/39	28		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher	College Towson State Teachers	East Orange, N. J.	

13. FATHER'S NAME: EUGENE McLaughlin

14. MOTHER'S MAIDEN NAME: EVELYN BONDS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	155-32-3202	Hospital Records	

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 289.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Hypoxia, Hypercarbia	≈ 18 hrs
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(B) DUE TO Pseudomonas Pneumonitis	2 weeks
	(C) Mucoviscidosis	27 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/18 1967 to 12/6 1967, that (I) (we) last saw the deceased alive on 12/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John R. Sharp M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12/6/67

23C. PHYSICIAN'S NAME (Type): John R. Sharp M.D.

23D. ADDRESS: Johns Hopkins Hosp

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	12/7/67	Mt. Hebron Cemetery	Mt. Clair, N. J.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 8 1967	Robert E. Fahey	Wm. J. Tickner & Sons	Balto. Md. North Pa.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V.S. 153 12-20-67 M.H.

R-550

BIRTH NO. 67 11743

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11743

1. NAME OF DECEASED (Type or Print): Cindy Susan Runion

2. DATE AND HOUR OF DEATH: Dec. 6, 1967 4: 25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hospital, 3100 Wyman Pk. Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Manns Choice
D. STREET ADDRESS (If rural, give location):

V-35

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: 9/20/54
9. AGE (In years last birthday): 13
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Russell Runion
14. MOTHER'S MAIDEN NAME: Emma Seifert

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Records- US PHS Hospital, Balto, Md.
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 204.3 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diffuse bronchopneumonia — Days

DUE TO

(B) Acute lymphocytic leukemia — Weeks

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Thrombocytopenia cretinism — Life

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 5 1967 to Dec. 6 1967, that (I) (we) last saw the deceased alive on Dec. 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Seana Hirschfeld M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/7/67
23C. PHYSICIAN'S NAME (Type): Seana Q. Hirschfeld, MD M.D.
23D. ADDRESS: US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Removal
24B. DATE: 12/7/67
24C. NAME of CEMETERY or CREMATORY: Cemetery St. Thomas Catholic Church
24D. LOCATION (City, town, or county) (State): Bedford, Pa.

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Wm. J. Tickner & Sons
ADDRESS: Balto. Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

H-251

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11744

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. X 67 11744

1. NAME OF DECEASED (Type or Print): Hasenbalg, Mary A

2. DATE AND HOUR OF DEATH: 12-4-67 | 11 07 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Baltimore, Maryland

B. COUNTY: Balt. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Towson

53-00

D. STREET ADDRESS (If rural, give location): 926 Southerly Rd.

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 5/19/04

9. AGE (In years last birthday): 63

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family records

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 7352.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A)	Hypoxia, Cardiac & Respiratory Arrest	minutes
(B) DUE TO	Anemia, Uremia, Intracerebral and Generalized bleeding	3 weeks
(C)	Polycystic System disease Kidneys, liver	15 years.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 11/11 1967 to 12/4 1967, that (I) (we) last saw the deceased alive on 12/4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John R. Sharp M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12/4/67

23C. PHYSICIAN'S NAME (Type): John R. Sharp M.D.

23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Dec. 7, 1967

24C. NAME of CEMETERY or CREMATORY: Dulaney Valley Memorial

24D. LOCATION (City, town, or county) (State): Cockeysville, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

25B. NAME OF REGISTRAR: Robert E. Farkas

25C. FUNERAL DIRECTOR: John Burns' Sons, Towson, Maryland

ADDRESS:

VS 150-REV. 1/1/65

S-160

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 11745 **CERTIFICATE OF DEATH** Registered No. 67 11745

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SCHAEFER, GEORGE N.

2. DATE AND HOUR OF DEATH: 12/05/67 8:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: Balto Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21207 53-00
D. STREET ADDRESS (If rural, give location): 1301 ST AGNES LANE

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: 02/18/16
9. AGE (In years last birthday): 51 — If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DRAFTSMAN
10B. KIND OF BUSINESS OR INDUSTRY: Gas & Elec. Co.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: GEORGE SCHAEFER
14. MOTHER'S MAIDEN NAME: CARRIE SCHULTZ
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes — (If yes, give war or dates of service): W.W. 2
16. SOCIAL SECURITY NO.: 218-05-3237
17. INFORMANT: ST AGNES RECORDS-WILKENS & CATON AVES. — ADDRESS

MEDICAL CERTIFICATION

1B. 153.31

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Tumoral Cachexia
DUE TO
(B) Disseminated Metastasis
DUE TO
(C) Adeno Ca of the Sigmoid.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 8-15-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Exploratory laparotomy for Ca.
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes Disseminated Ca of Sigmoid.

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DECEMBER 4, 1967 to DECEMBER 5, 1967, that (I) (we) last saw the deceased alive on DECEMBER 5, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alejandro Mejia M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/05/67
23C. PHYSICIAN'S NAME (Type): ALEJANDRO MEJIA M.D.
23D. ADDRESS: ST AGNES HOSPITAL-WILKENS & CATON AVES

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-8-1967
24C. NAME of CEMETERY or CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967
25B. NAME OF REGISTRAR: Robert E. Jenkins
25C. FUNERAL DIRECTOR: G. Howard Strong — ADDRESS: 3207 W. North Ave.,

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-16 1

BIRTH NO. 67 11746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11746

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SCHEAFER SCHEAFER, LEO C.

2. DATE AND HOUR OF DEATH: 12/6/67 2 30 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto 12-02
D. STREET ADDRESS (If rural, give location): 33rd & Charles Sts. Black Stone Apts

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 5-11-02
9. AGE (In years last birthday): 65
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant
10B. KIND OF BUSINESS OR INDUSTRY: HAMBURGERS
11. BIRTHPLACE (State or foreign country): Penna
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown ANGELO ~~XXXXX~~ SCHEAFER
14. MOTHER'S MAIDEN NAME: ELLEN KILEY ~~XXXXXXXXXXXXXX~~

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-03-5207-A MER AD
17. INFORMANT: chart
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

1B. 157X

(A) Cancer of pancreas

DUE TO (B) c̄ peritoneal spreading

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (C) c̄ metastasis of the Liver.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 20 1967 to Dec 6 1967, that (I) (we) last saw the deceased alive on Dec 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: T. Limpawuchara M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/6/67
23C. PHYSICIAN'S NAME (Type): T. LIMPAWUCHARA, MD. TONEG LIMPAWUCHARA M.D.
23D. ADDRESS: Union Memorial Hosp

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/9/67
24C. NAME of CEMETERY or CREMATORY: CATHEDRAL
24D. LOCATION (City, town, or county) (State): BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967
25B. NAME OF REGISTRAR: Robert E. Fahey
25C. FUNERAL DIRECTOR: H. W. MEARS & SON
ADDRESS: 805 N. CALVERT ST.

VS 150-REV. 1/1965

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R 0001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11747 Registered No. 67 11747

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) WINFIELD S. ROE SR. Winfield S Roe

2. DATE AND HOUR OF DEATH 12/5/67 Dec. 5, 1967 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital 48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Balto Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00
D. STREET ADDRESS (If rural, give location) 6214 Mount Ridge Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Married	12-25-97	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman

10B. KIND OF BUSINESS OR INDUSTRY Garrett-Buchanan

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Walter Roe

14. MOTHER'S MAIDEN NAME Josephine Plummer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) no

(If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 215 07 1890

17. INFORMANT Mrs Dorothy R. Roe ADDRESS 6314 Mt. Ridge Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac arrest

DUE TO

(B) CHF

~~DUE TO~~ and

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) Severe emphysema

434.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

?

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 11/30 1967 to 12/5 1967, that ~~I~~ (we) last saw the deceased alive on 12/5 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE Ralph Reymond M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED 12/5/67

23C. PHYSICIAN'S NAME (Type) Ralph REYMOND M.D.

23D. ADDRESS Maryland Gen. Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE Dec 8, 1967

24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. DEC 8 1967

25B. NAME OF REGISTRAR Robert E. Farley

25C. FUNERAL DIRECTOR STERLING FUNERAL ESTATE ADDRESS 736 Edm.

VS 150-REV. 1/1/65

P-636

67 11748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11748

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Pearl Porter

2. DATE AND HOUR OF DEATH: 12/4/67 - 1:50 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

27-20

D. STREET ADDRESS (If rural, give location): 3405 MENLO DRIVE #2]2]5

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: OCTOBER 1, 1914

9. AGE (In years last birthday): 53

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES SCHREIBER

14. MOTHER'S MAIDEN NAME: LILLIAN KLAWANSKY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1

(A) Ac. Pulm. Edema — INTERVAL BETWEEN ONSET AND DEATH: 30 min.

DUE TO

(B) HASCVD c

DUE TO

(C) Previous Myocardial Infarctions

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of breast

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1963 to 1967, that (I) (we) last saw the deceased alive on 12/4/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Daniel Bakal M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-4-67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12-5-67

24C. NAME of CEMETERY or CREMATORY: OHR KNESSETH ISRAEL ANSHE SFARD

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

25B. NAME OF REGISTRAR: Robert E. Fisher

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS, INC.

ADDRESS: 6010 REISTERSTOWN ROAD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-5161

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11749

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11749

1. NAME OF DECEASED (Type or Print): PUMPHREY, MORRIS L.

2. DATE AND HOUR OF DEATH: DECEMBER 6, 1967 9:06A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: A.A.Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): FERNDALE 52-00

D. STREET ADDRESS (If rural, give location): 202 A WILHELM AVE.

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 6-30-02

9. AGE (In years last birthday): 65

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED WATCHMAN

10B. KIND OF BUSINESS OR INDUSTRY: SCHULTE FORD

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ADDISON PUMPHREY

14. MOTHER'S MAIDEN NAME: FLORENCE R. GREEN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-18-5452

17. INFORMANT: ST. AGNES HOSPITAL RECORDS

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 287X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Congestive Heart Failure

DUE TO

(B) Atrial fibrilation

DUE TO

(C) Obesity ASCVD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonitis.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 26 1967 to DECEMBER 6 1967, that (I) (we) last saw the deceased alive on DECEMBER 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alejandro Mejia M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12/06/67

23C. PHYSICIAN'S NAME (Type): ALEJANDRO MEJIA M.D.

23D. ADDRESS: ST AGNES HOSPITAL - WILKENS & CATON AVES.

24A. BURIAL CREMATION, REMOVAL (Specify): CREMATION

24B. DATE: 9 Dec 67

24C. NAME of CEMETERY or CREMATORY: LOUDON PARK CEM.

24D. LOCATION (City, town, or county) (State): BALTIMORE, Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: KIRKLEY FUNERAL HOME

ADDRESS: Glen Burnie

VS 150-REV. 1/1/65

D-26 1/2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11750 Registered No. 67 11750

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): John Dickerson

2. DATE AND HOUR OF DEATH: Dec. 6, 67 1:30PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

CERTIFICATE AMENDED 12-11-67

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 1-01
D. STREET ADDRESS (If rural, give location): 2907 FAIT Ave

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: Feb. 1, 1895
9. AGE (In years last birthday): 72
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE, Md.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: GEORGE DICKERSON
14. MOTHER'S MAIDEN NAME: MARY ORICE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Carlene Bailey, 2907 Fait Ave. (Daughter
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

540.0

(A) Portal cirrhosis of liver with esophageal varices — months

DUE TO

(B) Chronic peptic ulcer of stomach — 1 yr

DUE TO

(C) Pneumonia, right lower lobe — 1 week

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: chronic and acute pyelonephritis — years

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 29 1967 to Dec. 6 1967, that (I) (we) last saw the deceased alive on Dec. 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Nam Doh Yang M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: Dec 6, 1967
23C. PHYSICIAN'S NAME (Type): NAM DOH YANG M.D.
23D. ADDRESS: Bon Secours Hospital, Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-9-67
24C. NAME of CEMETERY or CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: Thelma A. Hoffman
ADDRESS: 3218 Sudan St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V.S. 153 12-11-67 M.H.

1

5-520 67 11751 BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11751

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CARROLL M. JONES

2. DATE AND HOUR PRONOUNCED DEAD: December 7, 1967 7:55 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1918 W. Lanvale Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-04

D. STREET ADDRESS (If rural, give location): 1918 W. Lanvale Street

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 12-11-1911

9. AGE (In years last birthday): 55

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PORTER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Jones

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 212-10-8037

17. INFORMANT: VIRGINIA JONES

ADDRESS: SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 151 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma of stomach with metastases

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: December 7, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/11/67

23C. NAME of CEMETERY or CREMATORY: Arbutus Meh. Pk.

23D. LOCATION (City, town, or county) (State): Arbutus, Maryland

24A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Kelson Funeral Home

ADDRESS: 1348 Calhoun St.

VS 151-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-464

BIRTH NO.

M.E. CASE NO.

67 11752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11752

1. NAME OF DECEASED (Type or Print): MARY CLARELLI

2. DATE AND HOUR OF DEATH: 6 DEC 1967 | 6 30/ A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 32 MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: X

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 3-02

D. STREET ADDRESS (If rural, give location): 107 ALBEMARLE ST.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 5-29-95

9. AGE (In years last birthday): 72

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOU SEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: RES.

11. BIRTHPLACE (State or foreign country): ITALY

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ANTHONY DE NOIA

14. MOTHER'S MAIDEN NAME: IRENE SPER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: HOSPITAL RECORDS. ADDRESS

MEDICAL CERTIFICATION

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CARDIOVASCULAR COLLAPSE — HOURS

DUE TO

(B) HEART BLOCK — WEEKS (?)

DUE TO

(C) ASHD — YEARS

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS — YEARS

19A. DATE OF OPERATION: 29 & 30 NOV 67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: PACEMAKER INSERTION

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from NOV 24 1967 to 6 DEC 1967, that (I) (we) last saw the deceased alive on 6 DEC 1967 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. A. Dean Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 7 Dec. 67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/11/67

24C. NAME of CEMETERY or CREMATORY: ST. RAYMOND

24D. LOCATION (City, town, or county) (State): BRONX N.Y.

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Frank Della Nose

ADDRESS: 322 S. HIGH ST.

VS 150-REV. 1/1/65

1
G-642
T-460

67 11753

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11753

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPHINE F. GORALSKI (Taylor)

2. DATE AND HOUR PRONOUNCED DEAD: December 5, 1967 | 5:55 PM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Maryland General Hospital D.O.A.

48/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1526 Park Ave.

1409

5. SEX: M Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: 3/13/1890
9. AGE (In years last birthday): 77
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walenty Dembeck
14. MOTHER'S MAIDEN NAME: Katherine Augustyniak

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Leon J. Taylor
ADDRESS: 1526 Park Ave Apt 5 D.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection XX Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes X Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER X
ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.

EXAMINER'S NAME (Type): Edward F. Wilson, MD.

DATE SIGNED: December 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12/9/67
23C. NAME of CEMETERY or CREMATORY: St. Stanislaus Cemetery
23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967
24B. NAME OF REGISTRAR: Robert E. Farkas
24C. FUNERAL DIRECTOR: George A. Weber
ADDRESS: 705 S. Ann Street
George A. Weber

VS 151-REV. 1/1/65

T-416

BIRTH NO. 67 11754

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11754

1. NAME OF DECEASED (Type or Print): LULA TALBERT (HANKERSON)

2. DATE AND HOUR OF DEATH: 12/4/67 12 30 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO MD 28-02

D. STREET ADDRESS (If rural, give location): 4304 WENTWORTH RD

5. SEX: F

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): W

8. DATE OF BIRTH: 4/18/92

9. AGE (In years last birthday): 75

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): GA, Augusta

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ishman Hankerson

14. MOTHER'S MAIDEN NAME: Betty Hankerson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: UNK.

17. INFORMANT: Mrs. Mary White

ADDRESS: 2000 Bryant Ave

MEDICAL CERTIFICATION

1B. 903.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) Fractured Right Femur

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fx of Femur

CERTIFICATION APPROVED BY: Robert White M.D. CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: 12/1/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Fractured right femur

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): ☐ ☒

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 4304 WENTWORTH RD #7 28-02

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 11/29/67 8 00 AM

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☒

21F. HOW DID INJURY OCCUR? Tripped over table leg & fell

22. I certify that (I) (this hospital) attended the deceased from NOV 29 1967 to DEC 4 1967, that (I) (we) last saw the deceased alive on DEC 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Waddox Sothoron M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12/4/67

23C. PHYSICIAN'S NAME (Type): W. Haddox SOTHORON M.D.

23D. ADDRESS: UNIV OF MD HOSP BALTO MD

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-7-67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park

24D. LOCATION (City, town, or county): Arbutus (State): Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Morton E. Dyett F.H.

ADDRESS: 1701 Laurens

VS 150-REV. 1/1/65

N 821.2

H5 V61

Pending final approval of Medical Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

J-525 67 11755

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 66-21583

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11755

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CRAIG A. JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD: December 5, 1967 | 9:25 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Lutheran Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-07
D. STREET ADDRESS (If rural, give location): 502 Lyndhurst St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored	INFANT	Oct 9, 1966	1				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES PRESTON
14. MOTHER'S MAIDEN NAME: SYLVIA MARIE JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: -0-
17. INFORMANT: Mrs. Annie Talley ADDRESS: 1712 W. Mulberry St

MEDICAL CERTIFICATION

18. E983X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rupture of liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 502 Lyndhurst St. 20-07

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12/5 bet. 12noon and 9 p.m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Unknown

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12-8-67
23C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Park
23D. LOCATION (City, town, or county) (State): Arbutus, Maryland

24A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967
24B. NAME OF REGISTRAR: Robert E. Lankey M.D.
24C. FUNERAL DIRECTOR: MORTON & DYETT F.H.
ADDRESS: 1701 Laurens St.

VS 151-REV. 1/1/65

N864.2

M-6 24

67 11756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11756

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARSHALL, NANNIE

2. DATE AND HOUR OF DEATH: 12/7/67 | 5 45 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

9-08

D. STREET ADDRESS (If rural, give location): 666 COKESBURY AVE. #18

5. SEX: F

6. RACE: C

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW

8. DATE OF BIRTH: 5/4/10

9. AGE (In years last birthday): 57

If Under 1 Yr. Months: Days: Hours: If Under 24 Hrs. Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNEMPL

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Chesterfield, South Carolina

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Roque Turnage

14. MOTHER'S MAIDEN NAME: Mammie Buchannon

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: ODESSA ROBINSON

ADDRESS: 1729 MONPELIER ST. BALTO. MD.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I: DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

170X

(A) METASTATIC CA BREAST — INTERVAL BETWEEN ONSET AND DEATH: 9 YRS

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1958

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca BREAST

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/6 19 67 to 12/7 19 67, that (I) (we) last saw the deceased alive on 12/7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Charles S. Brown M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/7/67

23C. PHYSICIAN'S NAME (Type): DR. CHARLES S. BROWN M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-11-67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Pk.

24D. LOCATION (City, town, or county): Balto. (State): Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

25B. NAME OF REGISTRAR: Charles E. Lankey

25C. FUNERAL DIRECTOR: Morton E. Dept F.H.

ADDRESS: 1701 Lawrence St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-000

BIRTH NO. 67 11757

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11757

1. NAME OF DECEASED (Type or Print): ALEXANDER DAY

2. DATE AND HOUR OF DEATH: Dec 5, 1967 | 8:55P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 7-02

D. STREET ADDRESS (If rural, give location): 2536 Madison St.

5. SEX: M

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: 4/8/1900

9. AGE (In years): 67

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caterer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William E. Day

14. MOTHER'S MAIDEN NAME: Emma Cane King

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-09-3349

17. INFORMANT: Mrs. Temperance Day

ADDRESS: 2536 Madison Ave

MEDICAL CERTIFICATION

I

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardiac arrest — 9:55 12/5/67

DUE TO

(B) Myocardial infarction - ASCVD — 11/21/67

DUE TO

(C) (R) middle cerebral thrombosis - ASCVD — 11/23/67

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/5/67 1:00A 19 67 to 8:55PM 19 67, that (I) (we) last saw the deceased alive on 12/5/67 8:55 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A Sgluzhakow M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Dec 5, 1967

23C. PHYSICIAN'S NAME (Type):

23D. ADDRESS: M.O.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-9-67

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

25B. NAME OF REGISTRAR: Robert E. Foxley

25C. FUNERAL DIRECTOR: Morton & Dyett F.H.

ADDRESS: 1701 Laurens St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
H-620

67 11758 BALTIMORE CITY HEALTH DEPARTMENT 67 11758

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DEBORAH C. HARRIS

2. DATE AND HOUR PRONOUNCED DEAD: December 6, 1967 8:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Provident Hospital (DOA)

39/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-01
D. STREET ADDRESS (If rural, give location): 1615 Edmondson Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Negro	Single	5-2-1948	19				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Hochschild-Kohn	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: KATHERINE COLLINS

14. MOTHER'S MAIDEN NAME: WILLIAM HARRIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-46-9188

17. INFORMANT: Mrs. Katherine Harris ADDRESS: 1615 Edmondson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

353.2

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Status epilepticus
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: December 7, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	12-11-67	Mount Calvary Cem.	A.A. CO., Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 8, 1967	Robert E. Stakeman	MORTON & DYETT F.H.	1701 Laurens St.

VS 151-REV. 1/1/65

D-128

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11759

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ZACK DAVIS (JACK)

2. DATE AND HOUR OF DEATH: 12/7/67 2:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

8-04

D. STREET ADDRESS (If rural, give location): 2137 East Chase Street 21213

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widower

8. DATE OF BIRTH: 7-19-1892

9. AGE (In years last birthday): 75

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10B. KIND OF BUSINESS OR INDUSTRY: BETH-STEEL

11. BIRTHPLACE (State or foreign country): Virginia, Isle of Wright

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Willie Davis

14. MOTHER'S MAIDEN NAME: Masson ~~Brown~~ Clemmons

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-10-5204

17. INFORMANT: Records: BCH-4940 Eastern Avenue

ADDRESS: 21224

MEDICAL CERTIFICATION

18. 019.2 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PROBABLE MILIARY TUBERCULOSIS — INTERVAL BETWEEN ONSET AND DEATH: 3 months

DUE TO

(B) GRAM NEGATIVE SEPSIS — 2 weeks

DUE TO

(C) Anemia and pancytopenia — 1 month

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 15 NOVEMBER 19 67 to 7 DECEMBER 19 67, that ~~I~~ (we) last saw the deceased alive on 7 DECEMBER 19 67 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Michael R. McMillan M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 7 December 1967

23C. PHYSICIAN'S NAME (Type): Michael McMillan M.D.

23D. ADDRESS: 4940 Eastern Avenue, BALTIMORE CITY HOSPITALS, BALTIMORE, MD 21224

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12-10-67

24C. NAME of CEMETERY or CREMATORY: Shiloh Bapt. Ch. Cem.

24D. LOCATION (City, town, or county) (State): Smithfield, Virginia

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

25B. NAME OF REGISTRAR: Robert E. Sankey M.D.

25C. FUNERAL DIRECTOR: Morton & Degelt F.H.

ADDRESS:

VS 150-REV. 1/1/65

L520 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11760 Registered No. 67 11760

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LEAMUS, CHARLES

2. DATE AND HOUR OF DEATH: 4 00 pm 12/3/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15 13

D. STREET ADDRESS (If rural, give location): 4237 PARK HEIGHTS AVE

5. SEX: M

6. RACE: N N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH: 2/3/01

9. AGE (In years last birthday): 66

If Under 1 Yr. Months Days Hours Min. / If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Anthony Leamus

14. MOTHER'S MAIDEN NAME: Mary Queen

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 055-14-5994

17. INFORMANT: Mrs Gladys Leamus, same ADDRESS:

MEDICAL CERTIFICATION

18. 527.2

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PULMONARY EMBOLUS — 10-15 min

DUE TO

(B) COR PULMONALE — ?

DUE TO

(C) OBSTRUCTING LUNG DISEASE — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIGITOXICITY?

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): ✓

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov 28 1967 to Dec 3 1967, that (I) (we) last saw the deceased alive on Dec 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alan F. Wolf M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ✓

23B. DATE SIGNED: 12/3/67

23C. PHYSICIAN'S NAME (Type): ALAN F. WOLF, M.D.

23D. ADDRESS: C/o Sinai Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/8/67

24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetry

24D. LOCATION (City, town, or county) (State): A A County Md

25A. DATE REC'D BY HEALTH DEPT. DEC 8 1967

25B. NAME OF REGISTRAR: Robert E. Tuckey M.D.

25C. FUNERAL DIRECTOR: Adolphus Halstead ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

43-49-94 ED 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. R-534 67 11761 Registered No. 67 11761

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Randolph, Harold

2. DATE AND HOUR OF DEATH: 12/3/67 1:12 48 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 716 N. Appleton St. 21217

1604

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 10-1-95
9. AGE (In years last birthday): 72
If Under 1 Yr. Months: Days: Hours: If Under 24 Hrs. Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: BCH: Records 4940 Eastern Ave. Baltimore, Md. ADDRESS # 21224

MEDICAL CERTIFICATION

18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Myocardial Infarction — 13 days

(B) DUE TO:

(C):

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from 12/1/67 19 to 12/3/67 19, that (I) (we) last saw the deceased alive on 12/3/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert N Hill M.D. — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X
23B. DATE SIGNED: 12/3/67
23C. PHYSICIAN'S NAME (Type): Robert N. Hill M.D.
23D. ADDRESS: Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/8/67
24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetry
24D. LOCATION (City, town, or county) (State): A A County Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: Adolphus Halstead ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

m-620

67 11762

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11762

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LUKE (MARRIS) Morris

2. DATE AND HOUR PRONOUNCED DEAD: December 4, 1967 | 10:45 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 513 W. Biddle St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 513 W. Biddle St.

17-01

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored	?	?	70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Luke Morris

14. MOTHER'S MAIDEN NAME: Mattie Dent

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): ?

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRs Mildred Williams, ADDRESS: 631 W Mulberry St

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I

420.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

DATE SIGNED: December 4, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/8/67

23C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetry

23D. LOCATION (City, town, or county) (State): A A County Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

24B. NAME OF REGISTRAR: Charles E. Faulkner

24C. FUNERAL DIRECTOR: Adolphus Halstead

ADDRESS: 1206 W North Ave

VS 151-REV. 1/1/65

SAB-50-66-841

B-600

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

67 11763

Registered No. 67 11763

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): LULA BOYER

2. DATE AND HOUR OF DEATH: 12-5-67 | 7.30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS
4940 Eastern Avenue, Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2601 ULMAN AVE. 21215

15-12

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): 2 TIMES.
8. DATE OF BIRTH: 3-12-88
9. AGE (In years last birthday): 79
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES SMITH
14. MOTHER'S MAIDEN NAME: ELLEN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: DAUGHTER
ADDRESS: Records: BCH-4940 Eastern Avenue SAME 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 293X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) BACTERIEMIA — 5 days
DUE TO
(B) Decubitus Sores & infection — 2 years
DUE TO
(C) Anemia unknown etiology — 2 years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-28 1967 to 12-5 1967, that (I) (we) last saw the deceased alive on 12-5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: G. Alarcón M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-5-67
23C. PHYSICIAN'S NAME (Type): Garciela Alarcon
GRACIELA ALARCÓN M.D.
23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland 21224
BALTIMORE CITY HOSPITALS MED. DEPT.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/12/67
24C. NAME of CEMETERY or CREMATORY: National Cemetry
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967
25B. NAME OF REGISTRAR: Robert E. Farley
25C. FUNERAL DIRECTOR: Adolphus Halstead
ADDRESS: 1206 W. North Ave

VS 150-REV. 1/1/65

1

C-416 67 11764

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11764

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): OLIVER COLBURN

2. DATE AND HOUR PRONOUNCED DEAD: December 7, 1967 1:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Johns Hopkins Hospital (DOA)

33 99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-02
D. STREET ADDRESS (If rural, give location): 2707 Ashland Avenue 21205

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	Oct.18.1894	73				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dairy Worker	Retired	Annapolis Maryland	USA

13. FATHER'S NAME: Colburn

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service): 217

16. SOCIAL SECURITY NO.: 05 9626 A

17. INFORMANT: Mrs Viola May Colburn ADDRESS: 2707 Ashland Avenue 21205

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection [X] Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: December 7, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/11/67	Baltimore Cemetery	Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

24B. NAME OF REGISTRAR: Robert E. Farley

24C. FUNERAL DIRECTOR: Henry Sander & Sons Inc.
ADDRESS: Baltimore, Maryland

VS 151-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B-650 67 11765

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11765

1. NAME OF DECEASED (Type or Print): Guy Brown

2. DATE AND HOUR OF DEATH: 12-5-67 | 5:20 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc.

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 14-03

D. STREET ADDRESS (If rural, give location): 1814 Madison Avenue

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced

8. DATE OF BIRTH: Sept 13 1896

9. AGE (In years last birthday): 71

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service): YES

16. SOCIAL SECURITY NO.: 286-07-2810

17. INFORMANT: Anthony Grant — ADDRESS: 1703 Eutaw Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.): 782.9

(A) DUE TO: Shock, Etio ?

(B) DUE TO:

(C):

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from November 30, 1967 to December 5, 1967, that (I) (we) last saw the deceased alive on December 5, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Laredo M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12-6-67

23C. PHYSICIAN'S NAME (Type): Dr. C. Laredo M.D.

23D. ADDRESS: 1514 Division Street Balto., Maryland

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-11-67

24C. NAME of CEMETERY or CREMATORY: Baltimore Nat Cem

24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Elroy Alexander — ADDRESS: 1001 Beaumont Ave

VS 150-REV. 1/1/65

K 2421

67 11766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11766

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mary Kozlowski

2. DATE AND HOUR OF DEATH: 12-6-67 | 10-45 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD

B. COUNTY: Balto Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

53-00

D. STREET ADDRESS (If rural, give location): BOX 115 BURKE Ave. Bowley QUARTERS.

20

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married widowed

8. DATE OF BIRTH: 12/8/1894

9. AGE (In years last birthday): 72

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: John Futia

14. MOTHER'S MAIDEN NAME: Mary.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Julia Orzalek ADDRESS: RT. 15 BOX 612 B

MEDICAL CERTIFICATION

1B. 260 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

(B) Diabetic Coma Diabetes — "

DUE TO

(C) Diabetes Mellitus

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/5 1962 to 12/6 1967, that (I) (we) last saw the deceased alive on 12/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: NENITA SUAREZ M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/6/67

23C. PHYSICIAN'S NAME (Type): Nenita Suarez M.D.

23D. ADDRESS: Church Home & Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/9/67

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: B. DABROWSKI ADDRESS: 2818 E. Balto. St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

R. 236

67 11767

BALTIMORE CITY HEALTH DEPARTMENT

67 11767

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WOODROW W. RICHTER, SR.

2. DATE AND HOUR PRONOUNCED DEAD: December 7, 1967 | 3:10 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Mercy Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: [redacted] Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Orchard Beach
D. STREET ADDRESS (If rural, give location): 1200 Beach Promenade Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	MARRIED	DEC. 10, 1918	48				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
ELECTRICIAN	DAIRY PRODUCTS.	MARYLAND	U.S.A

13. FATHER'S NAME: CHARLES RICHTER

14. MOTHER'S MAIDEN NAME: LOUISA SCHWARTZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO

(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.:

17. INFORMANT: MARJORIE RICHTER

ADDRESS: 1200 BEACH PROMENADE

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 4221 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES	YES

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 8, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	12-11-67	LOUDON PARK	BALTIMORE, MD

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 8 1967	Robert E. Farley M.D.	GEO. L. SCHWAB FUNERAL HOME Francis W. Miller	2101 Frederick Ave.

VS 151-REV. 1/1/65

B-3001

67 11768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11768

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MATTHEW C BUTTA

2. DATE AND HOUR OF DEATH: 12-7-67 1:05 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JENKINS MEMORIAL HOSPITAL 1000 S caton Ave. Baltimore, Md. 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 504 Charing Cross Rd. 21229

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 12-5-1896

9. AGE (In years last birthday): 71

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10B. KIND OF BUSINESS OR INDUSTRY: Business

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Wenseslaus Butta

14. MOTHER'S MAIDEN NAME: Mary Prokop

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES

(If yes, give war or dates of service): WORLD WAR I

16. SOCIAL SECURITY NO.: 213 03 3756 A

17. INFORMANT: M D Kohler

ADDRESS: Medical Records- Jenkins Mem'l

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — 1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

DUE TO

(B) Cerebral arteriosclerosis — years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Chronic Brain Syndrome — 7 yrs.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/31 1965 to 12/7 1967, that (I) (we) last saw the deceased alive on 12/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. Raymond Gladue M.D. Attending Phys. ☒ Med. Director ☒ Staff Phys. ☐

23B. DATE SIGNED: 12/8/67

23C. PHYSICIAN'S NAME (Type): J. RAYMOND GLADUE M.D.

23D. ADDRESS: JENKINS MEM'L HOSP -1000 S Caton Ave.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/11/67

24C. NAME of CEMETERY or CREMATORY: OAKLAWN CEM

24D. LOCATION (City, town, or county) (State): BALTO MD

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: WEBER FUNERAL HOME

ADDRESS: 5311 Belmont Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-5001

67 11769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11769

BIRTH NO.

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Catherine Semma

2. DATE AND HOUR OF DEATH: 12-7-67 2:30P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Bolton Hill Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: 14 N. Luzerne Ave.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 6-02
D. STREET ADDRESS (If rural, give location): Maryland

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 12-1-96
9. AGE (In years last birthday): 71
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Seamstress
10B. KIND OF BUSINESS OR INDUSTRY: Tailor Shop
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: ~~Unknown~~ Ivan Mislowsky
14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Martha Kerloff

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): ——
16. SOCIAL SECURITY NO.: 216-28-5243A
17. INFORMANT: John Semma 6730 Boston Street
ADDRESS: Boltol Hill Records

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 18. 332 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Recurrent Cerebral Thrombosis — 3 days
DUE TO
(B) Cerebral Arteriosclerosis — Unknown
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart Disease — Unknown

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov 29 1967 to Dec 7 1967, that (I) (we) last saw the deceased alive on Dec 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Roland T. Smoot M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/7/67
23C. PHYSICIAN'S NAME (Type): ROLAND T. SMOOT M.D.
23D. ADDRESS: 3817 COPLEY RD, BALTO. 15

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 11 67
24C. NAME of CEMETERY or CREMATORY: Holy Trinity Cemetery
24D. LOCATION (City, town, or county): Elkridge (State): Howard Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: The Dippel Bros Inc
ADDRESS: 1800 E Lombard St

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. H-536 67 11770

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11770

1. NAME OF DECEASED (Type or Print): Bertha M. Hunter

2. DATE AND HOUR OF DEATH: 12/6/67 7:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21-02
D. STREET ADDRESS (If rural, give location): 1207 W. Cross St.

5. SEX: Female
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 4/2/1898
9. AGE (In years last birthday): 69
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick W. Hunter
14. MOTHER'S MAIDEN NAME: Clara Presser

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs Clara Nolan — ADDRESS: above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 260X

(A) Myocardial infarction — 1 day
DUE TO
(B) Arteriosclerotic Heart Disease — 6 months
DUE TO
(C) Diabetes Mellitus — 10 years

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 10 1957 to Dec 6 1967, that (I) (~~we~~) last saw the deceased alive on Dec 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: John P. Urlock Jr M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Dec 7, 1967
23C. PHYSICIAN'S NAME (Type): JOHN P. URLOCK JR M.D.
23D. ADDRESS: 1227 Washington Blvd

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/9/67
24C. NAME of CEMETERY or CREMATORY: Woodlawn Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: John F. Cowan & Son Inc.
ADDRESS: 90 Hollins St. 23, Md.

VS 150-REV. 1/1/65

M-635

BIRTH NO. 67 11771

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11771

1. NAME OF DECEASED (Type or Print): Martin, Luther

2. DATE AND HOUR OF DEATH: 12-7-67 | 7:15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 8-02
D. STREET ADDRESS (If rural, give location): 1705 N. Patterson Pk Ave.

5. SEX: M
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 5-16-15
9. AGE (In years last birthday): 52
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10B. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jesse Martin
14. MOTHER'S MAIDEN NAME: Mary Carter

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 224-10-0058
17. INFORMANT: MRS. NANNIE MARTIN
ADDRESS: 1705 PATTERSON PK AVE

CAUSE OF DEATH

1B. 181.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Sepsis	10 days
DUE TO (B)	infected cystectomy wound	2 month
DUE TO (C)	Carcinoma of Bladder	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 9/27/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinoma of Bladder
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/2 1967 to 12/7 1967, that (I) (we) last saw the deceased alive on 7 AM 12/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harry Pond M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/7/67
23C. PHYSICIAN'S NAME (Type): HARRY POND M.D.
23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/11/67
24C. NAME of CEMETERY or CREMATORY: MT AUBURN CEM.
24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967
25B. NAME OF REGISTRAR: Robert E. Tankey M.D.
25C. FUNERAL DIRECTOR: WM. C. MARCH
ADDRESS: 928 E NORTH AVE

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

1

P450 67 11772

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11772

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIE H. PULLIAM

2. DATE AND HOUR PRONOUNCED DEAD: December 7, 1967 | 9:15 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33/99 Johns Hopkins Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-03

D. STREET ADDRESS (If rural, give location): 1301 Lakewood Ave.

5. SEX: Male

6. RACE: Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: May 7 1921

9. AGE (In years last birthday): 46

If Under 1 Yr. Months | Days | Hours | If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Pulliam

14. MOTHER'S MAIDEN NAME: Sadie Tucker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service: YES

16. SOCIAL SECURITY NO.

17. INFORMANT: Thomas A. Pulliam ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E981X

i DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Shotgun wound of the chest

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

ii OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Sidewalk

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Biddle St. and Milton Ave. 8-03

21D. TIME OF INJURY (APPROX.): (Month) 12 (Day) 7 (Year) 67 (Hour) 9:00 p

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Man approached by offender and shot

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [XX] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 8, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12-13-67

23C. NAME of CEMETERY or CREMATORY: Baltimore Nat Cem

23D. LOCATION (City, town, or county) (State): Baltimore Md 21229

24A. DATE REC'D BY HEALTH DEPT.: DEC 8 1967

24B. NAME OF REGISTRAR: Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR: Elroy Wilson

ADDRESS: 1000 Manchester

VS 151-REV. 1/1/65

N875.4

C-506

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11773

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FANNIE CHINN

2. DATE AND HOUR OF DEATH: Dec 9, 1967 7:20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ~~3407 W Rogers Ave~~ 3407 W. ROGERS AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Md
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-17
D. STREET ADDRESS (If rural, give location): 3407 W. Rogers Ave

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: June 12, 1907
9. AGE (In years, last birthday): 60 60
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Ret
10B. KIND OF BUSINESS OR INDUSTRY: Bookkeeper
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LOUIS
14. MOTHER'S MAIDEN NAME: BAILEY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NOW
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-22-7231
17. INFORMANT: Husband
ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 170X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic carcinomatosis — Several years
DUE TO
(B) Carcinoma of breast — Several years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from May 1967 to Dec 9 1967, that (I) (~~we~~) last saw the deceased alive on Dec 8 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Seymour H. Rubin M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Dec 9, 1967
23C. PHYSICIAN'S NAME (Type): Seymour H. Rubin M.D.
23D. ADDRESS: 5415 Park Heights Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 12/10/67
24C. NAME of CEMETERY or CREMATORY: Har Menuchos
24D. LOCATION (City, town, or county) (State): Jerusalem, Israel

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Sylvan S. Levison Sons, Inc.
ADDRESS: Garrison Md

VS 150-REV. 1/1/65

D-400

67 11774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11774

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LOTTIE E DOLL

2. DATE AND HOUR OF DEATH: 12/8/1967 4 40 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1729 N. Montford Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Penna. B. COUNTY: York

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Rural Fawn Twp. V-35

D. STREET ADDRESS (If rural, give location): New Park

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	9/19/1876	91		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	York Co., Penna.	USA

13. FATHER'S NAME: Amos Harmon

14. MOTHER'S MAIDEN NAME: Horsettia Matthews

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: J.R.Scott, 1729 N. Montford Ave. Md.

ADDRESS: Baltimore,

MEDICAL CERTIFICATION

1B. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic Cardio-Vascular Disease

INTERVAL BETWEEN ONSET AND DEATH: Several Years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from November 6 19 67 to December 8 19 67, that (I) (~~we~~) last saw the deceased alive on December 5 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Loy M. Zimmerman M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Dec. 8, 67

23C. PHYSICIAN'S NAME (Type): Loy M. Zimmerman M.D.

23D. ADDRESS: 3202 Harford Rd. Baltimore Md

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/12/67	Centre Presby. Cem.	Fawn Twp., York Co., Penna.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Tankersley

25C. FUNERAL DIRECTOR: Guy M. Klerfelt Jr.

ADDRESS: Stewartstown, Pa.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-640

BIRTH NO. 67 11775

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11775

1. NAME OF DECEASED (Type or Print): ARMOND TERRELL

2. DATE AND HOUR OF DEATH: 12/6/67 1:20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: ST MARY'S Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): HOLLYWOOD 68-00

D. STREET ADDRESS (If rural, give location): ROUTE #1 BOX 99B 20636

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 3-29-08

9. AGE (In years last birthday): 59

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER(RETIRED)

10B. KIND OF BUSINESS OR INDUSTRY: CIVIL SERVICE

11. BIRTHPLACE (State or foreign country): NEW JERSEY

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN TERRELL

14. MOTHER'S MAIDEN NAME: DOROTHY COSS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 077 03 1868

17. INFORMANT: MRS. HELEN TERRELL ADDRESS: SAME AS #4

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bleeding Esophageal Varices — 24 hours

DUE TO

(B) Portal Hypertension — 8-12 months

DUE TO

(C) Alcoholic Cirrhosis of the Liver — 4 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/5 1967 to 12/6 1967, that (I) (we) last saw the deceased alive on 12/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John R. Stone, M.D.

M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12/6/67

23C. PHYSICIAN'S NAME (Type): JOHN R. STONE M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/9/67

24C. NAME of CEMETERY or CREMATORY: TRINITY MEMORIAL CEM.

24D. LOCATION (City, town, or county) (State): WALDORF, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Fankenna

25C. FUNERAL DIRECTOR: John M. Welch

ADDRESS: JOHN M. WELCH - LEONARDTOWN, MD.

VS 150-REV. 1/1/65

THE BODY OF ARMOND TERRELL WAS RELEASED AS NON MEDICAL BY DOCTOR CONOSTAVOLU OF THE MEDICAL EXAMINER'S OFFICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-25

38

BIRTH NO. 67 11776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11776

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FRANK J. BACON

2. DATE AND HOUR OF DEATH: DEC. 5, 1967 | 1 05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY OF MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MD. B. COUNTY: 20-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE D. STREET ADDRESS (If rural, give location): 405 S. PAXSON ST.

5. SEX: M | 6. RACE: W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED | 8. DATE OF BIRTH: 3/11/91 | 9. AGE (In years last birthday): 76 | If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER | 10B. KIND OF BUSINESS OR INDUSTRY: HOUSE | 11. BIRTHPLACE (State or foreign country): MD. | 12. CITIZEN OF WHAT COUNTRY?: US.

13. FATHER'S NAME: THOMAS BACON | 14. MOTHER'S MAIDEN NAME: GALLAGHER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: 217-01-7917 | 17. INFORMANT: HOSPITAL RECORD | ADDRESS:

MEDICAL CERTIFICATION

18. 585X 7 I 260X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO

(B) Empyema of Gall Bladder — days

DUE TO

(C) Acute cholecystitis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus. Arterio sclerotic cardiovascular disease

19A. DATE OF OPERATION: 28 Nov 67 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Acute cholecystitis | 20A. AUTOPSY? (Yes or No): | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ | 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/27 1967 to 12/5 1967, that (I) (we) last saw the deceased alive on 12/5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: I. Frank Hartman M.D. | Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ | 23B. DATE SIGNED: 12/5/67

23C. PHYSICIAN'S NAME (Type): I. Frank Hartman M.D. | 23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL | 24B. DATE: 12-9-67 | 24C. NAME of CEMETERY or CREMATORY: LOUDON PARK CEMETERY | 24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967 | 25B. NAME OF REGISTRAR: Robert E. Foxley M.D. | 25C. FUNERAL DIRECTOR: WALTERS FUNERAL HOME | ADDRESS: PRATT & STRICKER STS.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
W-163

67 11777 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11777

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DONALD WEIFORD

2. DATE AND HOUR PRONOUNCED DEAD: December 6, 1967 11:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Church Home and Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: X
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-01
D. STREET ADDRESS (If rural, give location): 208 Mason Court

3/5/99

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	7/11/1923	44				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sheet Metal Worker	Eastern Venetian Blind	Va.	U.S.A.

13. FATHER'S NAME: Clarence Weiford, Sr.

14. MOTHER'S MAIDEN NAME: Bessie Downs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	?	Mary Weiford	208 Mason Court

MEDICAL CERTIFICATION

1B. 420.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection [X] Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: December 7, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/9/67	Glen Haven Cemetery	Glen Burnie Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 11 1967	Robert E. Fridenger	John J. Cowan & Son, Inc.	901 Hollins St. Balt. Md. 21223

VS 151-REV. 1/1/65

C-450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11778 Registered No. 67 11778

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LAWRENCE MEGINNEY CALLAHAN

2. DATE AND HOUR OF DEATH: 4 DEC 1967 7 10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: QUEEN ANNE'S CO.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): CENTREVILLE 21617 67-00
D. STREET ADDRESS (If rural, give location): 123 S. COMMERCE ST

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 5/13/02
9. AGE (In years last birthday): 65
If Under 1 Yr. Months: 5 Days: 21 Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELECTRIC APPLIANCE
10B. KIND OF BUSINESS OR INDUSTRY: DEALER AND SALESMAN
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LAWRENCE A. CALLAHAN
14. MOTHER'S MAIDEN NAME: AUGUSTA GUSSIE MEGINNEY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-32-6682
17. INFORMANT: WIFE — ADDRESS: MRS. MARJORIE W. CALLAHAN, CENTREVILLE, MD. 21617

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 177 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF PROSTATE — 10 YRS

DUE TO

(B) MULTIPLE METASTASES — 10 YRS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 12-1 1967 to 12-4 1967, that ~~I~~ (we) last saw the deceased alive on 12-4 1967 and that ~~in my~~ (our) opinion death occurred at the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Philip Miller Rahman M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12-4-67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL ~~CREMATION~~, ~~REMOVAL~~ (Specify): BURIAL
24B. DATE: DEC. 7, 1967
24C. NAME of CEMETERY or CREMATORY: WOODLAWN MEMORIAL PARK
24D. LOCATION (City, town, or county) (State): EASTON, TALBOT COUNTY, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Tankersley
25C. FUNERAL DIRECTOR: James H. Barton Jr. — ADDRESS: Barton Bros, Centreville, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-1400

BIRTH NO. 67 11779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11779

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): John C Kahl

2. DATE AND HOUR OF DEATH: Dec. 2, 1967 — 5:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Little Sis. of The Poor 1200 Valley St. Balt 21202

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 10-01
D. STREET ADDRESS (If rural, give location): 1200 Valley St.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 2.25.1884
9. AGE (In years last birthday): 83
If Under 1 Yr. Months: Days: Hours: If Under 24 Hrs. Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER Ret
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Co.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Kahl
14. MOTHER'S MAIDEN NAME: MARY Anne unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-24-5862T
17. INFORMANT: Little Sis. of The Poor
ADDRESS:

MEDICAL CERTIFICATION

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

1B. 420.1

CAUSE OF DEATH

(A) Massive Myocardial
DUE TO
(B) infarction
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1966 to Dec 2 1967, that (I) (we) last saw the deceased alive on Dec 2, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stanley Ankudas M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12.4.67

23C. PHYSICIAN'S NAME (Type): STANLEY Ankudas M.D.
23D. ADDRESS: 1101 MAIDEN Choice LANE BALT MD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-6-1967
24C. NAME of CEMETERY or CREMATORY: St. Joseph's Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: Lasorah Funeral Home 7401 Belair Road
ADDRESS: 34

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11780 Registered No. 67 11780

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN A. FREDERICK

2. DATE AND HOUR OF DEATH: 12-4-67 11,45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Balto Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21 53-00
D. STREET ADDRESS (If rural, give location): 1816 SUNNYSIDE RD,

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: 2-23-49
9. AGE (In years last birthday): 18
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY: Home Tutor
11. BIRTHPLACE (State or foreign country): Baltimore, City
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: WILBUR FREDERICK
14. MOTHER'S MAIDEN NAME: CAROLINE SCHMIDT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr Wilber G. Frederick
ADDRESS: 1818 Sunny Side R

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 7441 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac arrest — 20 minutes

DUE TO

(B) Cardiomyopathy — ~3 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO

(C) Duchenne Pseudohypertrophic muscular dystrophy — 14 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary Edema + ? Pneumonia — 4 days

19A. DATE OF OPERATION: 0 —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Dec 1 1967 to Dec 4 1967, that (I) (we) last saw the deceased alive on 12 noon Dec 4 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Stephen H Polmar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: Dec 4, 1967

23C. PHYSICIAN'S NAME (Type): STEPHEN H. POLMAR M.D.
23D. ADDRESS: JOHNS HOPKINS HOSP. BALTIMORE MD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-8-1967
24C. NAME of CEMETERY or CREMATORY: Zion Cemetery
24D. LOCATION (City, town, or county): Baltimore (State): Co. Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Farkas
25C. FUNERAL DIRECTOR: Lassahn Funeral Home
ADDRESS: 7401 Belair Road

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

600

BIRTH NO.

M.E. CASE NO.

67 11781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11781

1. NAME OF DECEASED (Type or Print): SARAH LOWERY

2. DATE AND HOUR OF DEATH: 12-7-67 9.25 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: Balto

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 1321 SPRING AVENUE 21206

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 1-18-83

9. AGE (In years last birthday): 84

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): PENNA.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WESLEY CLITES

14. MOTHER'S MAIDEN NAME: CATHERINE WITT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: ALVENIA JOHNSON ADDRESS: CORRINGANVILLE

MEDICAL CERTIFICATION

18. I 584X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) ~~DUE TO~~ CARDIAC ARREST PRIOR TO ANESTHESIA — ? several days

(B) ~~DUE TO~~ Cholelithiasis — years

(C) CIRRHOSIS 2° to COMMON DUCT OBSTRUCTION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Renal failure

CERTIFICATION APPROVED BY: Edward J. Wilson M.D. CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/3 1967 to 12/7 1967, that (I) (we) last saw the deceased alive on 12/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: G. Michael Vincent M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12/7/67

23C. PHYSICIAN'S NAME (Type): G. MICHAEL VINCENT M.D.

23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: DEC 11, 1967

24C. NAME of CEMETERY or CREMATORY: PORTER CEMETERY

24D. LOCATION (City, town, or county) (State): HYNDMAN BedFord Co. PA.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Tucker

25C. FUNERAL DIRECTOR: BURGEE FUNERAL HOME William R Kleber

ADDRESS: 3631 Falls Rd

VS 150-REV. 1/65

Released by Medical Examiner pending final approval

FUNERAL DIRECTOR: IMPORTANT! Dr. Wilson

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11782 Registered No. 67 11782

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mrs. Felice Vallonga

2. DATE AND HOUR OF DEATH: 12-7-67 | 9 A.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: 4911 St. Gemma Rd.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. Md. 28-09
D. STREET ADDRESS (If rural, give location):

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): W
8. DATE OF BIRTH: 7-25-84
9. AGE (In years last birthday): 83
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): ITALY
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: — Malispina
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Flora Huscio 4911 St Gemma Rd
ADDRESS 21229

CAUSE OF DEATH

MEDICAL CERTIFICATION

I — 1B. 331 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) C.V.A.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-29-67 19 to 12-7-67 9 a.m. 19, that (I) (we) last saw the deceased alive on 12-7-67 9 a.m. 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Mohamad M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12-7-67
23C. PHYSICIAN'S NAME (Type): Mohamadi M.D.
23D. ADDRESS: Bon Secours Hosp. Balto Md

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-11-67
24C. NAME of CEMETERY or CREMATORY: Redstone Cemetery
24D. LOCATION (City, town, or county) (State): Uniontown, Pennsylvania

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Burgee Funeral Home Balto Md
ADDRESS
By Hiram M Burgee Jr

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

5-530

67 11783 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11783

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BARBARA PEYTON SMITH

2. DATE AND HOUR PRONOUNCED DEAD: December 3, 1967 9:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 800 Cathedral Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-02

D. STREET ADDRESS (If rural, give location): 800 Cathedral Street

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Nov 2 1939

9. AGE (In years last birthday): 28

If Under 1 Yr. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Musician

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ralph G. Stone Sr

14. MOTHER'S MAIDEN NAME: Tabitha Peyton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 218362542

17. INFORMANT: Charles E Smith ADDRESS: 2123 St Paul St

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. E983X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrocranial injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Office building

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 800 Cathedral Street 11-02

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12-3-67 ? m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Struck multiple times with blunt instrument, then burned

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: December 7, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12-8-67

23C. NAME of CEMETERY or CREMATORY: Mountain View Cem.

23D. LOCATION (City, town, or county) (State): Howard Co Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

24B. NAME OF REGISTRAR: Robert E. Faulkner

24C. FUNERAL DIRECTOR: Burger Funeral Home

ADDRESS: Balto Md

By Horace M. Jones Jr

VS 151-REV. 1/1/65

N856.2

1

C-540

67 11784 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11784

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH C. CAMELLA

2. DATE AND HOUR PRONOUNCED DEAD: December 9, 1967 | 2:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-08

D. STREET ADDRESS (If rural, give location): 4236 Elsa Terrace

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	May 27 1910	57				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shipping Clerk	Bank	Maryland	USA

13. FATHER'S NAME: Joseph Camella

14. MOTHER'S MAIDEN NAME: Margaret T Crafton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Yes WW II

16. SOCIAL SECURITY NO.: 213035550

17. INFORMANT: Mrs Maybert L Camella ADDRESS: 4236 Elsa Terra

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E971.8

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Perforation of Esophagus Complicating Ingestion of Lye

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 4236 Elsa Terrace

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 11/23/67 5:15 P.M.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [XX]

21F. HOW DID INJURY OCCUR? Subj. drank liquid plummer

22. I certify that I held an Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [X] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 12/9/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12-12-67	Lorraine Park	Balto Co Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 11 1967	Robert E. Faulkner	Burger Funeral Home By Howard Burger Jr	3631 Falls Rd

N 964.0

VS 151-REV. 1/1/65

F-6521

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registrar's No. 67 11785

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Edwin A Franke

2. DATE AND HOUR OF DEATH: Dec. 7, 1967 | 12:15 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2303 Pentland Drive

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-07

D. STREET ADDRESS (If rural, give location): 2303 Pentland Drive

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	May 27, 1895	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Chief Inspector	Koppers Company	Indiana	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
August Franke	Louise Schaper

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	WW I	313-09-2981	Esther E. Heckman	same

MEDICAL CERTIFICATION

18. 420.1 + 260X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: CORONARY THROMBOSIS — 24 HOURS

(B) DUE TO: A.S.C.V. DISEASE. — ?

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: DIABETES MELLITUS — 16 YEARS

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this ~~hospital~~) attended the deceased from DECEMBER 1949 to DECEMBER 7, 1967, that (I) (~~we~~) last saw the deceased alive on DEC. 4, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Arthur Karfgin M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/7/67

23C. PHYSICIAN'S NAME (Type): Arthur Karfgin M.D.

23D. ADDRESS: 1532 Havenwood Rd Baltimore, Md

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/11/67	Dulaney Valley Cem.	Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 11 1967	Robert E. Talley M.D.	Leonard J Ruck Inc,	5305 Harford Rd

VS 150-REV. 1/1/65

m-431

67 11786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11786

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALBERT EDWARD MILLET

2. DATE AND HOUR OF DEATH: 12/6/67 | 10:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSP.

36

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

27-05

D. STREET ADDRESS (If rural, give location): 6519 GLENOAK AVE. 14

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 11/11/02

9. AGE (In years last birthday): 65

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY: Eastern Box Co

11. BIRTHPLACE (State or foreign country): LONDON, ENGLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WILLIAM MILLET

14. MOTHER'S MAIDEN NAME: ELLEN ADAMS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 037-12-6804

17. INFORMANT: Mrs Edna Millett

ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Sclerosis

DUE TO

(B) Intestinal obstruction

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

420.1

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/21 1967 to 12/6 1967, that (I) (we) last saw the deceased alive on 12/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Tomas G. Alvero M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/6/67

23C. PHYSICIAN'S NAME (Type): TOMAS A. ALVERO M.D.

23D. ADDRESS: FRANKLIN SQUARE HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/11/67

24C. NAME of CEMETERY or CREMATORY: Lorraine Park

24D. LOCATION (City, town, or county) (State): Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Fankyna

25C. FUNERAL DIRECTOR: Leonard J Ruck Inc

ADDRESS: 5305 Harford Rd

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-455 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11787

Registered No. 67 11787

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Percy Walter Coleman

2. DATE AND HOUR OF DEATH: Dec. 7, 1967 — 3 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Midtown Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 11-02

D. STREET ADDRESS (If rural, give location): 808 St. Paul Street

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): single

8. DATE OF BIRTH: II/I5/I88I

9. AGE (In years last birthday): 86

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stevadore

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Francis R. Coleman

14. MOTHER'S MAIDEN NAME: Mary (unknown)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 2I2-0I-9I08

17. INFORMANT: Elisha Shockley 8414 Nunley Drive 34

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

443X

(A) Cardio Respiratory Failure

DUE TO Massive Cerebral Hemorrhage

(B) Hypertensive - Art CVD

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 8 1961 to Dec 7 1967, that (I) (we) last saw the deceased alive on Dec 7 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We) (did)~~ (did not) view the body after death.

23A. SIGNATURE: Willard Applefeld M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/7/67

23C. PHYSICIAN'S NAME (Type): Willard Applefeld M.D.

23D. ADDRESS: 5901 Park Heights Ave Baltimore, Md

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: I2/8/67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: Leonard J Ruck Inc. 5305 Harford Rd

ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
R-340

67 11788 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11788

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLES J RIEDEL

2. DATE AND HOUR PRONOUNCED DEAD: December 6, 1967 6:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 3033 O'Donnell Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-01

D. STREET ADDRESS (If rural, give location): 3033 O'Donnell Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: Feb. 23, 1893.

9. AGE (In years last birthday): 74

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machinist

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George ~~Charles~~ Riedel

14. MOTHER'S MAIDEN NAME: Mary R. Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-09-8821

17. INFORMANT: Fr. Kenny

ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D.

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED December 7, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/9/67

23C. NAME of CEMETERY or CREMATORY: New Cathedral

23D. LOCATION (City, town, or county) (State): Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

24B. NAME OF REGISTRAR: Robert E. Foxley M.D.

24C. FUNERAL DIRECTOR: Leonard J Ruck Inc.

ADDRESS: 5305 Harford Rd

VS 151-REV. 1/1/65

M-206

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11789

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11789

1. NAME OF DECEASED (Type or Print): MEASE GEORGE

2. DATE AND HOUR OF DEATH: Dec 5th 1967 | 4-05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 LUTHERAN HOSPITAL 730, ASHBURTON ST. BALTIMORE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD B. COUNTY: Baltimore Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore (20) 53-00

D. STREET ADDRESS (If rural, give location): 5, compass Rd.

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 1-30-1889

9. AGE (In years last birthday): 78

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10B. KIND OF BUSINESS OR INDUSTRY: Martin Co.

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Prentenda Mease

14. MOTHER'S MAIDEN NAME: Mary E. Smith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 196 14 0869

17. INFORMANT: LULA MEASE

ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 334 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) cardiac failure & Pneumonia.

INTERVAL BETWEEN ONSET AND DEATH: 25 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B)

DUE TO (C) stroke

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

AsCVD

19A. DATE OF OPERATION: 0 —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED While At Work ☐ — Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 11-9-1967 to 12-5-1967, that (I) (we) last saw the deceased alive on 12-5-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: B.A. DESAI M.D. (Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑)

23B. DATE SIGNED: 12-5-1967

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/9/67

24C. NAME of CEMETERY or CREMATORY: Belair Memorial Gardens

24D. LOCATION (City, town, or county) (State): Belair, Harford Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Bruzdzinski Funeral Home

ADDRESS: 1407 Eastern Ave.

VS 150-REV. 1/1/65

C-514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11790

Registered No. 67 11790

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALBERT FRANKLIN CAMPBELL

2. DATE AND HOUR OF DEATH: Dec. 6, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 720 Light St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 22-01

D. STREET ADDRESS (If rural, give location): 720 Light St.

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Aug. 2, '88

9. AGE (In years last birthday): 79

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner

10B. KIND OF BUSINESS OR INDUSTRY: Tavern

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Albert Campbell

14. MOTHER'S MAIDEN NAME: Doni Campbell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212 34 9333

17. INFORMANT: Mrs. Margaret Gangi

ADDRESS: 720 Light St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

154 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of rectum — INTERVAL BETWEEN ONSET AND DEATH: 1year

DUE TO

(B) Arterio sclerotic heart disease — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/13/67 19 to 12/6/67 19, that (I) (we) last saw the deceased alive on 12/6/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harry Deibel M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/8/67

23C. PHYSICIAN'S NAME (Type): Harry Deibel M.D.

23D. ADDRESS: 1226 S. Hanover Street Balto. Md. 21230

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/9/67

24C. NAME of CEMETERY or CREMATORY: Glen Haven Mem. Pk

24D. LOCATION (City, town, or county) (State): Glen Burnie, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: JOHN F. DENNY, INC.

ADDRESS: 715 Light St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

2-2-20

BIRTH NO. 67 11791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11791

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LEONA ZUKOWSKI

2. DATE AND HOUR OF DEATH: 12/08/67 7:00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL CATON & WILKENS AVE. BALTIMORE, MARYLAND 21229

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 21222
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 6709 BOSTON AVENUE

26-36

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 03-13-90
9. AGE (In years last birthday): 77
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): POLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: MICHAEL POZNIK DECEASED
14. MOTHER'S MAIDEN NAME: MARY DECEASED

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 820 00 6275
17. INFORMANT CATON & WILKENS AVE. ADDRESS ST. AGNES HOSPITAL RECORDS/

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

18. 170X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF THE BREAST WITH METASTASIS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from ~~DECEMBER 8~~ NOVEMBER 15 19 67 to DECEMBER 8 19 67, that (X) (we) last saw the deceased alive on DECEMBER 8 19 67 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (XX) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): DR. RODOLFO REVILLA M.D.
23D. ADDRESS: CATON & WILKENS AVE. BALTO; MD. 21229

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-12-67
24C. NAME of CEMETERY or CREMATORY: Holy Rosary Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Fankyna
25C. FUNERAL DIRECTOR: Walter Dabrowski
ADDRESS: 1005 Dundalk Avenue

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11792 Registered No. X 67 11792

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HERBERT C. CARRUTH

2. DATE AND HOUR OF DEATH: 12/5/67 | 3 17 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: SOUTH CAROLINA
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ROCK HILL 29730 V-37
D. STREET ADDRESS (If rural, give location): 869 MYRTLE DR.

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 3-17-13
9. AGE (In years last birthday): 54 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Asst.General Manager
10B. KIND OF BUSINESS OR INDUSTRY: Textiles
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: R.A. CARRUTH
14. MOTHER'S MAIDEN NAME: LEONA HULSDY
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital records
ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I 421.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Valvular aortic stenosis + insufficiency Calcific — Years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia + probable sepsis.

19A. DATE OF OPERATION: 11/27/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Aortic stenosis + insuff.
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/25/67 19 to 12/5/67 19, that (I) (we) last saw the deceased alive on 12/5/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Crile Crisler, M.D. M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/5/67
23C. PHYSICIAN'S NAME (Type): ☒ Crile Crisler, M.D. M.D.
23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/6/67
24C. NAME of CEMETERY or CREMATORY: Laurel Wood Cemetery
24D. LOCATION (City, town, or county) (State): Rockhill, S.C.

25A. DATE REC'D BY HEALTH DEPT. DEC 11 1967
25B. NAME OF REGISTRAR
25C. FUNERAL DIRECTOR: Ullrich Funeral Home 4210 Belair Road.
ADDRESS

For Bass Funeral Home Rock Hill, S.C.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-6310

BIRTH NO. 67 11793

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11793

1. NAME OF DECEASED (Type or Print): TRAUT, ROSE

2. DATE AND HOUR OF DEATH: 12/7/67 1:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 26-02

D. STREET ADDRESS (If rural, give location): 4256 NICHOLAS AVENUE

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 11-24-93

9. AGE (In years last birthday): 74

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALBERT WARMBOLD

14. MOTHER'S MAIDEN NAME: MARY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. La Rue Bardroff

ADDRESS: 2508 Glencoe Road

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) cardiovascular failure

DUE TO

(B) myocardial infarction

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 5 1967 to Dec. 7 1967, that (I) (we) last saw the deceased alive on Dec. 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Philip Reid M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/7/67

23C. PHYSICIAN'S NAME (Type): PHILIP R. REID M.D.

23D. ADDRESS: J.H.H.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/9/67

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Parkville, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: R. L. B. E. Farley M.D.

25C. FUNERAL DIRECTOR: Ullrich Funeral Home

ADDRESS: 4210 Belair Road.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

SAB-50-70-121

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-200 67 11794

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11794

1. NAME OF DECEASED (Type or Print): GEORGE SCHUCK

2. DATE AND HOUR OF DEATH: 12/7/67 3:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 53-00
D. STREET ADDRESS (If total, give location): 2019 Bear Ridge Road Apt. 104 21219

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: June 20, 1923
9. AGE (In years lost birthday): 44 ~~45~~
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman,
10B. KIND OF BUSINESS OR INDUSTRY: Piling
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Schuck
14. MOTHER'S MAIDEN NAME: Margaret Laurie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Records: BCH-4940 Eastern Avenue
ADDRESS: 21224

MEDICAL CERTIFICATION

18. 443 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebrovascular accident — 2 days
DUE TO
(B) Hypertensive cardiovascular disease — 10 years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 NONE
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from ~~11~~ 5 DECEMBER 1967 to 7 DECEMBER 1967, that ~~I~~ (we) last saw the deceased alive on 7 DECEMBER 1967 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) ~~did not~~ view the body after death.

23A. SIGNATURE: Michael R. McMillan M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 7 December 1967

23C. PHYSICIAN'S NAME (Type): Michael McMillan M.D.
23D. ADDRESS: BALTIMORE CITY HOSPITALS 21224, BALTIMORE Md. 4940 Eastern Ave

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/11/67
24C. NAME of CEMETERY or CREMATORY: Forest Lawn Cemetery
24D. LOCATION (City, town, or county) (State): Youngstown, Ohio

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Doris E. Turkyna
25C. FUNERAL DIRECTOR: Ullrich Funeral Home 4210 Belair Road.
ADDRESS

VS 150-REV. 1/1/65

For Davis-Velker Funeral Home, Yooungstown, Ohio.

H-630

BIRTH NO. 67 11795

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11795

1. NAME OF DECEASED (Type or Print): MR CHARLES W HARROD

2. DATE AND HOUR OF DEATH: 12/7/67 3:45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY: 1914 VAN BUREN RD 21222

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE, MD Balto Co.

D. STREET ADDRESS (If rural, give location):

53-00

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: OCT. 23 1877

9. AGE (In years last birthday): 90 — If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED RENN RR—>

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): BALTIMORE, MD

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: JOHN — HARROD

14. MOTHER'S MAIDEN NAME: LAURA — HART

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO. 233 403

17. INFORMANT: MRS RUSSELL HARROD — ADDRESS: 1914 VAN BUREN

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PULMONARY EMBOLUS — 1 HOUR

DUE TO

(B) Cerebral vascular accident

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. myocardial ischemia

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/22/67 19 67 to 12/7/67 19 67, that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S J Manekin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/7

23C. PHYSICIAN'S NAME (Type): S. J. MANEKIN M.D.

23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/9/67

24C. NAME of CEMETERY or CREMATORY: DRUID RIDGE

24D. LOCATION (City, town, or county) (State): PIKESVILLE MD

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: ULLRICH FUNERAL HOME — ADDRESS: 4210 BELAIR

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-525

BIRTH NO. 67 11796

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11796

1. NAME OF DECEASED (Type or Print): Carrie Linsenmayer

2. DATE AND HOUR OF DEATH: Dec. 6, 1967 | 2 00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00

3607 Kimble Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-03

D. STREET ADDRESS (If rural, give location): 3607 Kimble Road

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Aug. 14, 1879

9. AGE (In years last birthday): 88

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Penna

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Mary Williams

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Dorothy Herman

ADDRESS: 3607 Kimble Road

MEDICAL CERTIFICATION

18. 444X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Generalized Arteriosclerosis — 10 yrs.

DUE TO Essential hypertension — 10 yrs.

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonitis

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 1956 to Dec. 6, 1967, that (I) (~~we~~) last saw the deceased alive on Dec. 6, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: W. H. Grenzer M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12.7.67

23C. PHYSICIAN'S NAME (Type): W. H. GRENZER M.D.

23D. ADDRESS: 1520 E. 33rd St.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12.8/67

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Parkville, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Farkyna

25C. FUNERAL DIRECTOR: Ullrich Funeral Home

ADDRESS: 4210 Belair Road.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-532 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11797 Registered No. X 67 11797

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RUTH INEZ BENTZ

2. DATE AND HOUR OF DEATH: 12/6/67 11:07 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: GLEN BURNIE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 52-00
D. STREET ADDRESS (If rural, give location): 601 MAYO ROAD

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 3/3/10
9. AGE (In years last birthday): 57
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HERBERT BLAIR
14. MOTHER'S MAIDEN NAME: MARGARET MURRAY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: FAMILY ADDRESS: SAME.

MEDICAL CERTIFICATION

18. 223 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) BRAIN TUMOR (MENINGIOMA)
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/20 1967 to 12/6 1967, that (I) (we) last saw the deceased alive on 12/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Thomas A. Alvero M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/6/67
23C. PHYSICIAN'S NAME (Type): THOMAS A. ALVERO M.D.
23D. ADDRESS: FRANKLIN SQUARE HOSP.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/9/67
24C. NAME of CEMETERY or CREMATORY: GLEN HAVEN CEM.
24D. LOCATION (City, town, or county) (State): GLEN BURNIE MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: McCully mf
ADDRESS: 237 Patapsco Ave 21225

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-5251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11798 Registered No. 67 11798

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Olive Dorcas Ransom

2. DATE AND HOUR OF DEATH: December 4, 1967 | 3:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Long Green Nursing Home 115 E. Melrose Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21229 28-04
D. STREET ADDRESS (If rural, give location): 531 Nottingham Road

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Nov. 24, 1908
9. AGE (In years last birthday): 59
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Charles H. Riley
14. MOTHER'S MAIDEN NAME: ~~Mrs~~ Cora Heaps

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Lewis F. Ransom, D.D. ADDRESS: 531 Nottingham Road 21229

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Cardiac Failure — 1 yr.
DUE TO
(B) Sec. Pneumonia
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Jan 10 1966 to Dec. 4 1967, that (I) (~~we~~) last saw the deceased alive on Dec. 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (did not) view the body after death.

23A. SIGNATURE: Laurence C. Post M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/6/67
23C. PHYSICIAN'S NAME (Type): LAURENCE C. POST M.D.
23D. ADDRESS: 6805 York Rd. Baltimore 21212 Md

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/7/67
24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, County, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Starkey M.D.
25C. FUNERAL DIRECTOR: McCully Funeral Home
ADDRESS: 237 Patapsco Ave. 21225

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 66-02786 67 11799 Registered No. 67 11799

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Michael Darrin Keener

2. DATE AND HOUR OF DEATH: 12/7/67 9 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: BALTIMORE Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): SPARROWS POINT 21219

D. STREET ADDRESS (If rural, give location): 1309 FORREST ROAD 53-00

5. SEX: MALE 6. RACE: CAUCASIAN 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): INFANT

8. DATE OF BIRTH: 2/14/1965 9. AGE (In years last birthday): 2 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: HOWARD E. KEENER

14. MOTHER'S MAIDEN NAME: JEAN HORSEY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: H. E. KEENER — AS #4 ABOVE. ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 193.4

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) NEUROBLASTOMA — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 9/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: NEUROBLASTOMA

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/4/67 19 to 12/9 19 67, that (I) (we) last saw the deceased alive on 12/7/67 19 67 and that in (my) (our) opinion death accurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Maria Y. Que M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-7-67

23C. PHYSICIAN'S NAME (Type): MARIA Y. QUE M.D.

23D. ADDRESS: MERCY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/8/1967

24C. NAME of CEMETERY or CREMATORY: OAKLAWN

24D. LOCATION (City, town, or county) (State): BALTO. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: W. Brooks Bradley Glendale, Md.

ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-4121

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 11800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11800

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SILVIUS, MARTHA MAE

2. DATE AND HOUR OF DEATH: DECEMBER 9, 1967 10:40A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MD. 21229

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 21043 Howard Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): ELLICOTT CITY 63-00

D. STREET ADDRESS (If rural, give location): RFD #2

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 1-7-18

9. AGE (In years last birthday): 49

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN ~~XXXXXX~~ RIDGLEY

14. MOTHER'S MAIDEN NAME: NANNIE THOMAS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: ST. AGNES HOSPITAL RECORDS

ADDRESS: BALTIMORE, MD. 21229

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart disease

DUE TO

(B) Spastic paralysis of extremities.

DUE TO

(C) Von Recklinghausens disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 17 19 67 to DECEMBER 9, 1967, that (X) (I) (we) last saw the deceased alive on DECEMBER 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: GEORGE ANGOV M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

DR. GEORGE ANGOV

23B. DATE SIGNED: 12/9/67

23C. PHYSICIAN'S NAME (Type): G. Angov M.D.

23D. ADDRESS: CATON & WILKENS AVES. BALTIMORE, MD. 21229

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-12-67

24C. NAME of CEMETERY or CREMATORY: MT VIEW

24D. LOCATION (City, town, or county) (State): Alpha Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Falkenhan

25C. FUNERAL DIRECTOR: Herbert Tom Black

ADDRESS: Ellicott City Md.

VS 150-REV. 1/1/65

5-530 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11801 Registered No. 67 11801

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SMITH JOSEPH

2. DATE AND HOUR OF DEATH: DECEMBER 4 1967 3:30A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: ST AGNES HOSPITAL
(If not in hospital or institution, give street address or location): CATON & WILKENS AVE BALTO MD 21229

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: CITIZEN- AUSTRIA- Howard
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ELLICOTT CITY 21043 63-60
D. STREET ADDRESS (If rural, give location): 781 WATERLOO RD

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 3/10/89
9. AGE (In years last birthday): 78
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: MINE WORKERS OF AM.
11. BIRTHPLACE (State or foreign country): AUSTRIA
12. CITIZEN OF WHAT COUNTRY? AUSTRIA

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 169-03-0965
17. INFORMANT: ST AGNES RECORDS ADDRESS: CATON & WILKESN

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 523.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart failure.
DUE TO
(B) Cor Pulmonale + A.S.C.V.D.
DUE TO
(C) Silicosis + Fibrosis Lungs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cavitation Upper Lobes Lungs.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 19 19 67 to DECEMBER 4 19 67, that XX (we) last saw the deceased alive on DECEMBER 4 19 67 and that in (X my) (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alejandro Mejia M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/4/67
23C. PHYSICIAN'S NAME (Type): ALEJANDRO MEJIA M.D.
23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-7-67
24C. NAME of CEMETERY or CREMATORY: Good Shepherd
24D. LOCATION (City, town, or county) (State): Ellicott City, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Fahey
25C. FUNERAL DIRECTOR: Higinbotham-Stack Funeral Home
ADDRESS: Ellicott City Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

31-35-49 ED 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. F-630 67 11802

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11802

1. NAME OF DECEASED (Type or Print): LULA FORWOOD

2. DATE AND HOUR OF DEATH: DEC. 6, 1967 | 7:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Ave., Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4940 Eastern Ave. # 21224

26-12

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 6-1-04
9. AGE (In years last birthday): 63
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Maryland Balto. Co.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Adam Popp
14. MOTHER'S MAIDEN NAME: Stella Chenowith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: BCH; Records
ADDRESS: 4940 Eastern Ave. Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I 334X+ 260X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cerebrovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 15 years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus — 5 years

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/12 1962 to 12/6 1967, that (I) (we) last saw the deceased alive on 12/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Benjamin Lechner, MD. M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: Dec 6, 1967
23C. PHYSICIAN'S NAME (Type): Benjamin Lechner M.D.
23D. ADDRESS: 4940 Eastern Ave. Baltimore, Maryland # 21224 BALT CITY HOSP.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-8-1967
24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Lassahn Funeral Home
ADDRESS: 7401 Belair Road 36

VS 150-REV. 1/1/65

G-635

67 11803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11803

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JACOB GRADMAN

2. DATE AND HOUR OF DEATH: Dec 7, 1967 | 1 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and township): BALTIMORE 27-20

D. STREET ADDRESS (If rural, give location): 3500 DEVONSHIRE DRIVE

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: July 26, 1889

9. AGE (In years last birthday): 79

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rt

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): GERMANY

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: RABBI BIRNBAUM

ADDRESS: Same

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial Infarction — minutes

DUE TO

(B) Arteriosclerosis — Unknown

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 7 1967 to December 7 1967, that (I) (we) last saw the deceased alive on December 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: David J. Miller M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Dec 7, 1967

23C. PHYSICIAN'S NAME (Type): DAVID MILLER M.D.

23D. ADDRESS: Lisson Rd Owings Mills, MD

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/8/67

24C. NAME of CEMETERY or CREMATORY: Chevra Ahavas Chesed

24D. LOCATION (City, town, or county) (State): ROSEDALE ~~Randallstown~~, Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: R. Lee & E. Fr. Chey, Md

25C. FUNERAL DIRECTOR: Sylvan S. Levin & Son, Inc

ADDRESS: Garrison Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

50-71-33 ED 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. K-620 67-24389 67 11804

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11804

1. NAME OF DECEASED (Type or Print): SANDRA T. KARES

2. DATE AND HOUR OF DEATH: DEC 7 1967 | 645 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITAL 4940 Eastern Ave. Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 2009 GUY WAY 21222 005

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: NOV 30 1967
9. AGE (In years lost birthday): 7 DAYS — If Under 1 Yr. Months: 0 Days: 7 — If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): BALTIMORE, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THOMAS KARES
14. MOTHER'S MAIDEN NAME: DOROTHY SAMPERY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: BCH: Records 4940 Eastern Ave. Baltimore, Md. ADDRESS #21224

MEDICAL CERTIFICATION

18. 7680 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) CARDIORESPIRATORY ARREST AND ASPIRATION
DUE TO
(B) NEONATAL SEPSIS
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH: 48 hours ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DEC 7, 8 00 AM 1967 to DEC 7, 6 45 pm 1967, that (I) (we) last saw the deceased alive on DEC 7, 6 50 pm 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ede Jonge M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: DEC 7, 1967
23C. PHYSICIAN'S NAME (Type): De Jonge M.D.
23D. ADDRESS: Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/8/67
24C. NAME of CEMETERY or CREMATORY: St. Stanislaus
24D. LOCATION (City, town or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Fahey
25C. FUNERAL DIRECTOR: M.F. SADOWSKI & SONS, ADDRESS: 1808 EASTERN AVE.

VS 150-REV. 1/1/65

SAB-49-05-17

G-560

BIRTH NO. 67 11805

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11805

1. NAME OF DECEASED (Type or Print): Michael Gummer (MICHAEL J, GUMMER)

2. DATE AND HOUR OF DEATH: 12-7-67 11 45 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Dundalk 53-00

D. STREET ADDRESS (If rural, give location): 3503 Logan View DR. 21222

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced

8. DATE OF BIRTH: 7-28-1892

9. AGE (In years last birthday): 75

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Iron Worker

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Gummer

14. MOTHER'S MAIDEN NAME: Anna ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes

(If yes, give war or dates of service): W.W. 1

16. SOCIAL SECURITY NO. A 213-01-0648-

17. INFORMANT: Records: BCH-4940 Eastern Avenue

ADDRESS: 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 595 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Chronic Renal Failure	4 months
	DUE TO (B)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-10- 1967 to 12-7- 1967, that (I) (we) last saw the deceased alive on 12-7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: J. R. Norris M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-7-67

23C. PHYSICIAN'S NAME (Type): J.R. Norris J. R. NORRIS M.D.

23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Md. Baltimore City Hospitals 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-9-67.

24C. NAME of CEMETERY or CREMATORY: Mt. Carmel Cemetery

24D. LOCATION (City, town, or county) (State): 5712 O'Donnell St. Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: Charles L. Giles

ADDRESS: 901 S. Conkling St. Balto., 21224, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-263

67 11806 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 11806 Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHNNY RICHARDSON

2. DATE AND HOUR PRONOUNCED DEAD: December 8, 1967 | 4:50 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital D.O.A.

43 99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: X

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 2528 Salerno Place

25-33

5. SEX: Male

6. RACE: Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: I-10-1914

9. AGE (In years last birthday): 53

If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10B. KIND OF BUSINESS OR INDUSTRY: Paper Factory

11. BIRTHPLACE (State or foreign country): Sumter S.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Richardson

14. MOTHER'S MAIDEN NAME: Phyllis Jefferson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Janie Richardson

ADDRESS: 2528 Salerno Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

416X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection [X] Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 8, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: I2-I2-67

23C. NAME of CEMETERY or CREMATORY: Mount Auburn

23D. LOCATION (City, town, or county) (State): Baltimore City

24A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

24B. NAME OF REGISTRAR: Robert E. Fankyna

24C. FUNERAL DIRECTOR: Isaiah L. Brown and Son

ADDRESS: 108 W. Montgomery Street

VS 151-REV. 1/1/65

1
J-525

67 11807

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11807

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CAROLINE JOHNSON - Carolyn

2. DATE AND HOUR PRONOUNCED DEAD: December 1, 1967 | 5:30 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 43/99 South Baltimore General Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-02
D. STREET ADDRESS (If rural, give location): 209 W. Hill St.

5. SEX: Female
6. RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 10-23- 1954
9. AGE (In years last birthday): 13
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry Johnson
14. MOTHER'S MAIDEN NAME: Elizabeth Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Harry Johnson
ADDRESS: 530 Hanover Street

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. E916.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia due to Carbon Monoxide Poisoning

DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 209 W. Hill St. 2nd floor 22-02

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12 1 67 4:50 p.m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Subject in house fire

22. I certify that I held an Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Edward F. Wilson,

DATE SIGNED: December 2, 1967

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12-7-67
23C. NAME of CEMETERY or CREMATORY: Mount Auburn Ct
23D. LOCATION (City, town, or county) (State): Baltimore City

24A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Isaiah L. Brown and Son
ADDRESS: 108 W. Montgomery Street

VS 151-REV. 1/1/65

N968.0

H-545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11808 Registered No. 67 11808

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Earl James Hamlin

2. DATE AND HOUR OF DEATH: (Sun.) 10 Dec '67 2:30 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND: ALSO KNOWN AS: - JAMES - EARL - HAMLIN

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital 38 22 S. Greene St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balt. City 23-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21230
D. STREET ADDRESS (If rural, give location): 29 East Randall St.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 11-19-16
9. AGE (In years last birthday): 51
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cab driver
10B. KIND OF BUSINESS OR INDUSTRY: Cab ~~driver~~ Company
11. BIRTHPLACE (State or foreign country): Maryland, Baltimore
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Thomas Hamlin
14. MOTHER'S MAIDEN NAME: Phoebe Ellen Tripp (~~No ? name given~~) Tripp

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 215-10-0665
17. INFORMANT: Virginia H. Short ADDRESS: Jackson Med Record. 132 W. Fort Ave. 21230

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 411 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days.

DUE TO

(B) Aortic Valve Replacement for Aortic Insufficiency

DUE TO

(C) due to Rheumatic Heart Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none.

19A. DATE OF OPERATION: 30 Nov '67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Aortic Insufficiency
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-26 1967 to 10 Dec 1967, that (I) (we) last saw the deceased alive on 10 Dec 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C M Anderson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 10 Dec '67
23C. PHYSICIAN'S NAME (Type): C. M. Anderson M.D.
23D. ADDRESS: Univ. Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 13-1967
24C. NAME of CEMETERY or CREMATORY: Cedar Hill Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn Md - 21225

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Fahey
25C. FUNERAL DIRECTOR: Curtis E. Evans ADDRESS: 1400 S. Charles St 21230

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

46-50-11 1
IW

P-623

BIRTH NO. 67 11809

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 11809

1. NAME OF DECEASED (Type or Print): PRESTON, JAMES

2. DATE AND HOUR OF DEATH: 9 DECEMBER 1967 12:20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 Eastern Avenue, Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE — Balto Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 53-00
D. STREET ADDRESS (If rural, give location): 1202 REISTERTOWN ROAD - 21208

5. SEX: MALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SEPERATED
8. DATE OF BIRTH: 12/4/98
9. AGE (In years last birthday): 69
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES PRESTON
14. MOTHER'S MAIDEN NAME: MARY E. SCOTT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-01-2411A
17. INFORMANT'S NAME AND ADDRESS: RECORDS: Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Md. 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. 492X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PNEUMONITIS
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CVA + ASCVD

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 16 JUNE 1967 to 9 DECEMBER 1967, that (I) (we) last saw the deceased alive on 9 DECEMBER 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Melvyn S. Tockman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 9 DECEMBER 1967
23C. PHYSICIAN'S NAME (Type): MELVYN S. TOCKMAN M.D.
23D. ADDRESS: BALTIMORE CITY HOSPITALS, 4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12-13-16
24C. NAME of CEMETERY or CREMATORY: MT AUBURN
24D. LOCATION (City, town, or county) (State): BALTIMORE Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Tarkington
25C. FUNERAL DIRECTOR: JOSEPH KNIGHT
ADDRESS: 1639 N. BROADWAY

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530

BIRTH NO. 67 11810

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11810

1. NAME OF DECEASED (Type or Print): Cumber, Mary Smith

2. DATE AND HOUR OF DEATH: 12/8/67 2:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto Md
D. STREET ADDRESS (If rural, give location): 1426 E Preston St

8-03

33

5. SEX: F
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): W
8. DATE OF BIRTH: 12/9/07
9. AGE (In years lost birthday): 59
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): COOK-DOMESTIC
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DELEWARE ROSE
14. MOTHER'S MAIDEN NAME: SYLVIA PRESTON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-16-3805
17. INFORMANT: OLIVER R. SMITH
ADDRESS: 4000 WINDSOR AVE.

MEDICAL CERTIFICATION

18. 199.21

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac arrest

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Probable metastatic malignancy

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/28 1967 to 12/8 1967, that (I) (we) last saw the deceased alive on 12/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Henry K Bennett M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/8/67
23C. PHYSICIAN'S NAME (Type)
23D. ADDRESS M.D.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12-13-67
24C. NAME of CEMETERY or CREMATORY: MT AUBURN
24D. LOCATION (City, town, or county) (State): BALTIMORE Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: JOSEPH KNIGHT
ADDRESS: 1639 N. BROADWAY

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

1

L-532

BIRTH NO. 67 11811

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11811

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ERNEST LINDSEY (Ernest Lindsey)

2. DATE AND HOUR OF DEATH: 12-6-67 9:35 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2331 EUTAW PLACE

1502

5. SEX: M
6. RACE: N
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 10-15-1900
9. AGE (In years last birthday): 67
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Track man
10B. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Anderson, N. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Preston Lindsey
14. MOTHER'S MAIDEN NAME: Eliza Hooker

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: MARY LINDSEY
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 334X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PROBABLE STROKE — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DELIRIUM TREMENS

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-1- 1967 to 12-6- 1967, that (I) (we) last saw the deceased alive on 12-6- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Michael R. Siegal M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12-1-67
23C. PHYSICIAN'S NAME (Type): MICHAEL R. SIEGAL M.D.
23D. ADDRESS: UNIVERSITY OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-11-67
24C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Park
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Farber, M.D.
25C. FUNERAL DIRECTOR: Charles R. Law
ADDRESS: 802 Madison Ave.

VS 150-REV. 1/1/65

N-200

BIRTH NO.

M.E. CASE NO. 67 11812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11812

1. NAME OF DECEASED (Type or Print): NAGY, NICHOLAS

2. DATE AND HOUR OF DEATH: DECEMBER 6, 1967 6:35 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21218

D. STREET ADDRESS (If rural, give location): 2734 REESE ST

9-04

44

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: ~~XXXXXXXXXXXXXXXX~~ 12-17-1890

9. AGE (In years lost birthday): ~~75~~ 76

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~XXXXXXXXXXXX~~ Laborer

10B. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): BUDAPEST, ~~HUNGARY~~ ~~XXXXX~~ Hungry

12. CITIZEN OF WHAT COUNTRY? ~~XXXXXXXXXXXXXX~~ ~~American~~ USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 060-07-4287

17. INFORMANT: Steven Nagy

ADDRESS: 3201 WESTERWALD BALTIMORE MD.

MEDICAL CERTIFICATION

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) ~~GASTRIC CARCINOMA~~ Marked Malnutrition — 1 year

DUE TO

(B) Duodenal ulcer

DUE TO

(C) Marked pulmonary emphysema

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 6 1967 to Dec. 6 1967, that (I) (we) last saw the deceased alive on Dec 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Cesar F. Climaco M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-6-67

23C. PHYSICIAN'S NAME (Type): ~~DR.~~ CESAR F. CLIMACO M.D.

23D. ADDRESS: ~~THE UNION MEMORIAL HOSPITAL~~

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-11-1967

24C. NAME of CEMETERY or CREMATORY: Prospect Hill Cem.

24D. LOCATION (City, town, or county) (State): Towson, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks, Inc.

ADDRESS: 1217 St. Paul St. Balto., Md. 21202

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. P-620 67 11813

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11813

1. NAME OF DECEASED (Type or Print): LARKIN H. PARKS

2. DATE AND HOUR OF DEATH: DEC. 8, 1967 | 7:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL
37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ~~BALT~~ MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 906 ST. PAUL ST
11-02

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: 8-25-88
9. AGE (In years last birthday): 79
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAYROLL CLERK
10B. KIND OF BUSINESS OR INDUSTRY: Hotel Industry
11. BIRTHPLACE (State or foreign country): BALTIMORE
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LEE PARKS
14. MOTHER'S MAIDEN NAME: SOPHIA PARKS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 223-12-7972
17. INFORMANT: MR. JAMES S. PARKS
ADDRESS: Rt. #10 Box 194 A Balt. Md. 21219

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
18. 239 X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) UREMIA
DUE TO
(B) RENAL SHUTDOWN
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 10-31, 12-7
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: MASS, SCALP, URINARY RETENTION
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10 / 18 19 67 to DEC. 8 19 67, that (I) (we) last saw the deceased alive on DEC 8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Samuel A. Torres M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12-8-67
23C. PHYSICIAN'S NAME (Type): SAMUEL A. TORRES M.D.
23D. ADDRESS: MERCY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Removal
24B. DATE: 12-9-1967
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Wm. Cook-Brooks, Inc.
ADDRESS: 1217 St. Paul St. Balto. Md. 21202

VS 150-REV. 1/1/65

W. 425

BIRTH NO. 67 11814

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11814

1. NAME OF DECEASED (Type or Print): BESSIE M. WILSON

2. DATE AND HOUR OF DEATH: DEC. 2, 1967 | 7:20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(If not in hospital or institution, give street address or location): 3403 COPLEY RD. BALTIMORE, MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: 15-11

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 3403 COPLEY RD.

5. SEX: F

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): DIVORCED

8. DATE OF BIRTH: 1/13/89

9. AGE (In years last birthday): 78

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MANICURIST

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick Douglass

14. MOTHER'S MAIDEN NAME: Annie Smith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-34-7053

17. INFORMANT: Sister (Jessie Jackson) ADDRESS: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 month

DUE TO

(B) Nephrosclerosis — unknown

DUE TO

(C) Arteriosclerotic cardiovascular disease — unknown (many years)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: none

19A. DATE OF OPERATION: none

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Summer of 1966 to Present 19..., that (I) (~~we~~) last saw the deceased alive on Dec 1, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: D. Stewart, M.D. M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/2/67

23C. PHYSICIAN'S NAME (Type): D. W. STEWART M.D.

23D. ADDRESS: 3414 Duvall Av. (21216)

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-5-67

24C. NAME of CEMETERY or CREMATORY: Fairview Cemetery

24D. LOCATION (City, town, or county) (State): Taylorsville Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Rayner Sanders ADDRESS: 217 E. Preston St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

(7)

V525

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11815

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11815

1. NAME OF DECEASED (Type or Print): Roy Mack Johnson

2. DATE AND HOUR OF DEATH: Dec. 7, 1967 | 6:00 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 731 Stamford Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 28-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 731 Stamford Rd.

5. SEX: M
6. RACE: Cauc.
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 6/25/99
9. AGE (In years last birthday): 68
(If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert ---
14. MOTHER'S MAIDEN NAME: Ada Meeks

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 215-22-7807
17. INFORMANT: Mrs. Roy Johnson — ADDRESS: 731 Stamford Rd. - 21229

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 443X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive & Arteriosclerotic Cardio Vasc. Disease
DUE TO
(B) & Cerebral Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 21, 1967 to Dec 7, 1967, that (I) (~~we~~) last saw the deceased alive on Dec 7, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the cause stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Harry L. Knipp M.D. — Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12-8-67
23C. PHYSICIAN'S NAME (Type): Harry L. Knipp M.D.
23D. ADDRESS: 4116 Edmondson Ave. Balto 29, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/11/67
24C. NAME of CEMETERY or CREMATORY: Baltimore National Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Witzke F. D. - 4101 Edmondson Av.

VS 150-REV. 1/1/65

1 (5)

B-425

67 11816

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11816

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BLANCHE MARIE BALSAMO

2. DATE AND HOUR PRONOUNCED DEAD: December 9, 1967 6:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): St. Agnes Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto Co
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1176 Newfield Avenue

53-00

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Married	9/15/28	~~40~~ 39				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		West Virginia	USA

13. FATHER'S NAME: Late Jacob Dameron

14. MOTHER'S MAIDEN NAME: Dona DePriest

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Robert L. Balsamo — ADDRESS: 1176 Newfield Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

500X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Asthmatic Bronchitis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 12/10/67

23A. BURIAL, CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY OR CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/14/67	Baltimore National Cem.	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 11 1967	Robert E. Farley M.D.	Witzke F. D.	4101 Edmondson Av.

VS 151-REV. 1/1/65

F. 6001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11817 Registered No. 67 11817

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FORE, WILLIE

2. DATE AND HOUR OF DEATH: 12-8-1967 | 3:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 Lutheran Hospital of Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 16-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 610 Wildwood Pkwy

5. SEX: F
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: 12/13/92
9. AGE (In years last birthday): 74
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin Dean
14. MOTHER'S MAIDEN NAME: Dixie Gilliam

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Con L. Silverthorn ADDRESS: 610 Wildwood Pkwy

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardio vascular disease — 1 year
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-28-1967 to 12-8-1967, that (I) (we) last saw the deceased alive on 12-8-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Nguyen Thi Oanh M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-8-67
23C. PHYSICIAN'S NAME (Type): NGUYEN THI OANH M.D.
23D. ADDRESS: Lutheran Hospital of Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/13/67
24C. NAME of CEMETERY or CREMATORY: Mt. CALVARY
24D. LOCATION (City, town, or county) (State): A. A. County, Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Tilley, M.D.
25C. FUNERAL DIRECTOR: Joseph G. Parks, Jr. ADDRESS: 1301 N. Central

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-36 [3]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11818

Registered No. 67 11818

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Thomas Stewart

2. DATE AND HOUR OF DEATH: 12-7-67 | 11:00 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: Provident Hospital Inc.

(If not in hospital or institution, give street address or location): 1514 Division Street, Baltimore, Maryland 21217

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: 14-03

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 2029 Madison Ave.

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 4/10/90

9. AGE (In years last birthday): 77

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): BALTO. Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas L. Stewart

14. MOTHER'S MAIDEN NAME: Frances Stepney

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Herbert Stewart

ADDRESS: 2029 Madison Ave

MEDICAL CERTIFICATION

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Congestive Heart Failure

DUE TO

(B) HCVD

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from October 27, 1967 to December 7, 1967, that (I) (we) last saw the deceased alive on December 7, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: G. S. Tengco M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12-8-67

23C. PHYSICIAN'S NAME (Type): G. S. TENGCO M.D.

23D. ADDRESS: 1514 Division Street

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/12/67

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn

24D. LOCATION (City, town, or county) (State): Balto. Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Lindsay

25C. FUNERAL DIRECTOR: Joseph S. Locke Jr.

ADDRESS: 1304 N. Central Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

50-59-35
IW
H.125

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11819 Registered No. 67 11819

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HUSTON HOBSON / HUSTON HOBSON

2. DATE AND HOUR OF DEATH: 12/8/67 1/2 15 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 Eastern Avenue, Baltimore, Maryland 21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 16-08
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3603 Harlem Avenue - 21229

5. SEX: MALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SEPARATED
8. DATE OF BIRTH: 6/16/07
9. AGE (In years last birthday): 60
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CREED HOBSON
14. MOTHER'S MAIDEN NAME: LENA JONES

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 217-07-9822
17. INFORMANT: RECORDS: Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Md. 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 161 X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Larynx — 6 years
DUE TO
(B) Respiratory Arrest
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hypercalcemia

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from 11/15 1967 to 12/8 1967, that (X) (we) last saw the deceased alive on 12/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Joel Thurm — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/8/67
23C. PHYSICIAN'S NAME (Type): JOEL THURM / JOEL THURM M.D.
23D. ADDRESS: BCH 4940 Eastern Avenue Baltimore, Md. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/11/67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Charles A Rice
ADDRESS: 66 W Barre

VS 150-REV. 1/1/65

SAB-50-48-24 1

BIRTH NO. H-162 67 11820

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11820

1. NAME OF DECEASED (Type or Print): AMELIA F. HABERKAM

2. DATE AND HOUR OF DEATH: 12/10/67 5:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4940 Eastern Avenue Baltimore, Maryland 21224

BALTIMORE CITY HOSPITALS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Baltimore Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): 53-60

D. STREET ADDRESS (If rural, give location): 21 Vista Mobile Drive 21222

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH: 12-14-82

9. AGE (In years last birthday): 84

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Shimek ~~James~~

14. MOTHER'S MAIDEN NAME: Mary Forst

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-32-5764

17. INFORMANT: Records: BCH-4940 Eastern Avenue ADDRESS: 21224

MEDICAL CERTIFICATION

I

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) ? BLEED 2° UREMIA

INTERVAL BETWEEN ONSET AND DEATH: ~2 mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) NEPHROSCLEROSIS

DUE TO

(C) GENERALIZED ARTERIOSCLEROSIS ASCVD; HX OF M.I.; CHF

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/29 1967 to 12/10 1967, that (I) (we) last saw the deceased alive on 12/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Paul E. Michelson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12/10/67

23C. PHYSICIAN'S NAME (Type): Paul Michelson PAUL MICHELSON M.D.

23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/13/'67

24C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: John A. Moran, Inc. ADDRESS: 3000 E. Baltimore St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

49-66-48 ED 1

BIRTH NO. W-416

67 11821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11821

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WOLFORD, VARDA

2. DATE AND HOUR OF DEATH: 12/7/67 3:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Ave., Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balt. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): Rt. 16, Box 106 A 21221 005

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 2-24-1910
9. AGE (In years last birthday): 57
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Body Maker
10B. KIND OF BUSINESS OR INDUSTRY: American Can Co
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Sophas~~ Seefus Stevenson
14. MOTHER'S MAIDEN NAME: Ollie Mae Grim

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 235-38-9814
17. INFORMANT: BCH: Records
ADDRESS: 4940 Eastern Ave. Baltimore, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 331 X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: CVA & Cerebrovascular — at least 1 yr.

(B) DUE TO: Hypertension

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/8 19 67 to 12/7 19 67, that (I) (we) last saw the deceased alive on 12/1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Leonard Lippman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/7/67

23C. PHYSICIAN'S NAME (Type): LEONARD LIPPMAN M.D.
23D. ADDRESS: 4940 Eastern Ave. Baltimore, Maryland BALT. CITY HOSPITALS # 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/11/67
24C. NAME of CEMETERY or CREMATORY: Holly Hill Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: John A. Moran, Inc.
ADDRESS: 3000 E. Baltimore St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

42-39-56 GG 1

S-500

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

67 11822 **CERTIFICATE OF DEATH** Registered No. 67 11822

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CONRAD SCHWINN

2. DATE AND HOUR OF DEATH: Dec. 6, 1967 9 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 943 Armistead Way 26-34

D. STREET ADDRESS (If rural, give location): BALTIMORE CITY HOSPITALS - 4940 Eastern Avenue 21224

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 11-25-81

9. AGE (In years last birthday): 86

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10B. KIND OF BUSINESS OR INDUSTRY: RR Baltimore & Ohio

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Conrad Schwinn

14. MOTHER'S MAIDEN NAME: Sarah Frances Noelworthy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: RECORDS: BCH 4940 EASTERN AVE. BALTO. 21224, MD.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 1B. 422.1 + 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Atherosclerotic cerebro vascular disease — > 20 years

DUE TO (B)

DUE TO (C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus — ?

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/6 1966 to 12/6 1967, that (I) (we) last saw the deceased alive on 12/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Benjamin Lechner, MD — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Dec 6, 1967

23C. PHYSICIAN'S NAME (Type): DR. BENJAMIN LECHNER M.D.

23D. ADDRESS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, 21224, MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/9/'67

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: John A. Moran, Inc.

ADDRESS: 3000 E. Baltimore St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-6361

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 11823 **CERTIFICATE OF DEATH** Registered No. 67 11823

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARTHA PORTER

2. DATE AND HOUR OF DEATH: 12/5/67 9 30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-38
D. STREET ADDRESS (If rural, give location): 5814 ALAMEDA

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): ~~S (NEVER MARRIED)~~
8. DATE OF BIRTH: 01/06/98
9. AGE (In years last birthday): 69
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired -Housewife
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): MARYLAND.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ~~ELI~~ ELIJAH TOADVINE
14. MOTHER'S MAIDEN NAME: DAISEY SHOCKLEY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MR. VIRGIL F. TOADVINE, JR. (nephew) ADDRESS: 518 S. Park Drive, Salisbury, Maryland

MEDICAL CERTIFICATION

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Congestive Heart Failure — 6 years
DUE TO
(B) Miocardial Infarction, old
DUE TO
(C) ASCVD
Pulmonary embolization — NOS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from October 28 1967 to December 5 1967, that (I) (we) last saw the deceased alive on December 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Enrique Cipriani M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/5/67
23C. PHYSICIAN'S NAME (Type): ENRIQUE CIPRIANI M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 8, 1967
24C. NAME of CEMETERY or CREMATORY: Union Church Cemetery
24D. LOCATION (City, town, or county) (State): Wicomico County, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Fankymer
25C. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11824 Registered No. 67 11824

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ELDAIDGE H. WOLFF

2. DATE AND HOUR OF DEATH: DECEMBER 7, 1967 | 2 05 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Dorchester Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Cambridge 59-13

D. STREET ADDRESS (If rural, give location): 615 Locust Street

5. SEX: MALE

6. RACE: CAUC

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 4/28/08

9. AGE (In years last birthday): 59

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PHYSICIAN

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: ELDAIDGE E. WOLFF

14. MOTHER'S MAIDEN NAME: MARIA C. HOOPER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Margaret F. Wolff, ADDRESS: 615 Locust St. Cambridge, Md.

MEDICAL CERTIFICATION

18. 446 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriolar nephrosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DECEMBER 1 1967 to DECEMBER 7 1967, that (I) (we) last saw the deceased alive on DECEMBER 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: DECEMBER 7, 1967

23C. PHYSICIAN'S NAME (Type): ARAME W. Williams M.D.

23D. ADDRESS: UNIVERSITY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Dec. 9, 1967

24C. NAME of CEMETERY or CREMATORY: Christ Churchyard

24D. LOCATION (City, town, or county) (State): Cambridge, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Falkner

25C. FUNERAL DIRECTOR: Kenneth R. Thomas ADDRESS: Cambridge, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
m-420

67 11825 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 67 11825

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EVELYN N. MALECKI

2. DATE AND HOUR PRONOUNCED DEAD: December 6, 1967 | 10:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Baltimore City Hospital (DOA)

31/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2832 O'Donnell Street

1-01

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: June 29, 1916
9. AGE (In years last birthday): 51
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Henry Helmick
14. MOTHER'S MAIDEN NAME: Arttie Phillips

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 213-24-7305
17. INFORMANT: Mr. Ronald Carr, 3011 Fait Ave. Balto. Md.
ADDRESS: 21224

MEDICAL CERTIFICATION

1B. 4221

CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: December 7, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12/10/67
23C. NAME of CEMETERY or CREMATORY: McNeeley Cemetery
23D. LOCATION (City, town, or county) (State): Tucker Co. Hendricks, W. Va.

24A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
24B. NAME OF REGISTRAR: Robert E. Fraley M.D.
24C. FUNERAL DIRECTOR: John J. Duda
ADDRESS: 7922 Wise Ave. Dundalk, Md.

VS 151-REV. 1/1/65

G-650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11826 Registered No. 67 11826

M.E. CASE NO.

~~Mamie Elizabeth Green~~

1. NAME OF DECEASED (Type or Print): GREEN, MAMIE ELIZABETH

2. DATE AND HOUR OF DEATH: 12/7/67 7:20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE City Hospitals 21224
4940 Eastern Avenue, Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: Baltimore Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Dundalk 53-0
D. STREET ADDRESS (If rural, give location): 8348 BEAR CREEK DRIVE 21222

5. SEX: fem 6. RACE: white 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED 8. DATE OF BIRTH: 11/22/13 9. AGE (In years last birthday): 54 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE 10B. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Irvin M. German 14. MOTHER'S MAIDEN NAME: Amelia L. Krodel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): 16. SOCIAL SECURITY NO.: None 17. INFORMANT: Records: BCH-4940 Eastern Avenue 21224 ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 443X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Sub arachnoid hemorrhage — 5 mos
DUE TO
(B) HCVD
DUE TO
(C) Pneumonia - Urinary tract infection

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Decubitus Ulcers

19A. DATE OF OPERATION: 7/21/67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Pneumonia 20A. AUTOPSY? (Yes or No): No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 14 1967 to 12/7 1967, that (I) (we) last saw the deceased alive on 12/7/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: M. Estruch M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 12/7/67

23C. PHYSICIAN'S NAME (Type): MYRNA T. ESTRUCH M.D. 23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland BALTIMORE City Hospitals

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 12/11/67 24C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery 24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967 25B. NAME OF REGISTRAR: Robert E. Farley, M.D. 25C. FUNERAL DIRECTOR: John J. Duda, 7922 Wise Ave. Dundalk, Md. ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11827 Registered No. 67 11827

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Russell Crider

2. DATE AND HOUR OF DEATH: 12/6/67 | 4:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland General

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: —
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 19-04
D. STREET ADDRESS (If rural, give location): 120 S. Mount St

5. SEX: Male
6. RACE: Caue
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Unknown
8. DATE OF BIRTH: 10/23/99
9. AGE (In years last birthday): 68
If Under 1 Yr. Months: — Days: — If Under 24 Hrs. Hours: — Min.: —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: General
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Crider Unk
14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Unknown (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 218-143-135
17. INFORMANT: Bolton Hill Nursing Home ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Thrombosis — Days
DUE TO
(B) Cerebral Atherosclerosis — Years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): —
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?: —

22. I certify that ~~I~~ (this hospital) attended the deceased from 12/4 1967 to 12/6 1967, that ~~I~~ (we) last saw the deceased alive on 12/5 1967 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: C. E. DiFilici M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/1/67
23C. PHYSICIAN'S NAME (Type): C. E. DiFilici M.D.
23D. ADDRESS: Maryland General Hosp. Balt. Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-10-67
24C. NAME of CEMETERY or CREMATORY: Mt Jackson
24D. LOCATION (City, town, or county) (State): Mt Jackson, Va.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Fahey
25C. FUNERAL DIRECTOR: Harry W. Haight
ADDRESS: Sykesville, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

m-600

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11828

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11828

1. NAME OF DECEASED (Type or Print): SAMUEL T. MURRAY

2. DATE AND HOUR OF DEATH: 12/8/67 8:17 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL
48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ~~3125 A~~ B. COUNTY: MARYLAND
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 16-02
D. STREET ADDRESS (If rural, give location): 3125 ABELL AVE

5. SEX: MALE
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 5-6-11
9. AGE (In years last birthday): 56
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): teacher
10B. KIND OF BUSINESS OR INDUSTRY: PUBLIC SCHOOLS
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: SAMUEL T. MURRAY SR.
14. MOTHER'S MAIDEN NAME: BEATRICE WASHINGTON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 212-10-9340
17. INFORMANT: (wife) LOIS T. MURRAY
ADDRESS: ABOVE

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ruptured ABD. AORTIC ANEURYSM — 1 DAY
DUE TO
(B) ARTERIOSCLEROSIS
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12/8/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ruptured ABD. AORTIC ANEURYSM
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (~~this hospital~~) attended the deceased from 12/8/67 5PM 19 to 12/8/67 8:17 PM 19, that (I) (~~we~~) last saw the deceased alive on 12/8/67 19 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: C. Thomas Flotte M.D. M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/8/67
23C. PHYSICIAN'S NAME (Type): C. THOMAS FLOTTE M.D.
23D. ADDRESS: 827 LINDEN AVE., BALTIMORE, MD. 21201

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-12-67
24C. NAME of CEMETERY or CREMATORY: Oxford
24D. LOCATION (City, town, or county) (State): ~~Oxf~~ Oxford Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co.
ADDRESS: 4905 York Rd.

VS 150-REV. 1/1/65

H-256

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11829

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11829

1. NAME OF DECEASED (Type or Print): HAGNER, JOSEPH

2. DATE AND HOUR OF DEATH: 12/8/67 10:15 pm M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): ~~4200 WEST VIEW RD. 21218~~ 28-41 Seton Institute

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 1/7/88
9. AGE (In years last birthday): 79
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~NONE~~ Retired-Hatmaker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS Hagner
14. MOTHER'S MAIDEN NAME: CATHERINE WENTZ

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NONE
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-05-9384
17. INFORMANT: ST. AGNES HOSPITAL RECORDS
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 593X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Gastrointestinal Bleeding & (3-4 days)
DUE TO Renal Failure
(B) Anyxemia & Renal Failure (Months).
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/6/ 19 67 to 12/8/ 19 67, that (I) (we) last saw the deceased alive on 12/8/ 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Raymond R. Bahr M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/8/67

23C. PHYSICIAN'S NAME (Type): R. BAHR M.D.
23D. ADDRESS: ST. AGNES HOSP; CATON & WILKENS AVES.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/11/67
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Fowler M.D.
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.
ADDRESS: 4905 York Rd. Balto. 12, Md.

VS 150-REV. 1/1/65

R-2010

BIRTH NO. 67 11830

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11830

1. NAME OF DECEASED (Type or Print): JOSEPH RODNEY RICE

2. DATE AND HOUR OF DEATH: 12-9-67 8 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hosp. 28 Wyman Park Drive Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-38
D. STREET ADDRESS (If rural, give location): 6130 Loch Raven Blvd

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): M.
8. DATE OF BIRTH: 4-15-02
9. AGE (In years last birthday): 65 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CWO - RET.
10B. KIND OF BUSINESS OR INDUSTRY: U.S. ARMY
11. BIRTHPLACE (State or foreign country): PA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ALFRED CURTIS RICE
14. MOTHER'S MAIDEN NAME: ~~MARY~~ CAROLINE McKinney

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): 1918 - 1949
16. SOCIAL SECURITY NO.: 203-10-4730
17. INFORMANT: Hospital Record. ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 420.1 - 200.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO

(B) ASCVHD — Years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Lymphosarcoma — Months

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 5, 1967 to Dec. 9, 1967, that (I) (we) last saw the deceased alive on Dec. 9, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William L Wilkie M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 10 Dec '67
23C. PHYSICIAN'S NAME (Type): William L Wilkie M.D.
23D. ADDRESS: Same as #3

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/13/67
24C. NAME of CEMETERY or CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co. ADDRESS: 4905 York Road Baltimore, Md. 21212

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

m-524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11831 Registered No. 67 11831

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Valeria G. Mengel

2. DATE AND HOUR OF DEATH: December 7, 1967 5:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): New Berlin
D. STREET ADDRESS (If rural, give location): 600 Market St,

V-35

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never Married
8. DATE OF BIRTH: 2/8/1894
9. AGE (In years last birthday): 73
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Registered Nurse
10B. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (State or foreign country): Sunbury, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis M. Mengel
14. MOTHER'S MAIDEN NAME: Grace O. King

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Olley Funeral Home, 539 Race St., Sunbury, Pa.
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 331 X

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension and
DUE TO
(B) Massive cerebral
DUE TO
(C) Hemorrhage

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Cleared by Dr. Gregory medical 19 to 19 and that (I) (we) last saw the deceased alive on Summer Bolt 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: Ralph g Hills M.D.
Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Dec 8, 1967
23C. PHYSICIAN'S NAME (Type): Ralph Hills M.D.
23D. ADDRESS: 18 E. Eager St.

24A. BURIAL, CREMATION, REMOVAL (Specify): Rem.-Burial
24B. DATE: 12/11/67
24C. NAME of CEMETERY or CREMATORY: West Side
24D. LOCATION (City, town, or county) (State): Shamokin Dam, Snyder County, Pa.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co.
ADDRESS: 4905 York Road Baltimore, Md. 21212

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-53b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11832 Registered No. 67 11832

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Louise D. Kennedy

2. DATE AND HOUR OF DEATH: Dec. 6, 1967 | 5:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 218 Homewood Terrace

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-07

D. STREET ADDRESS (If rural, give location): 218 Homewood Terrace

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 4/17/1887

9. AGE (In years last birthday): 80

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Cyrus Kennedy

14. MOTHER'S MAIDEN NAME: Florence Face

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: Walter E. Kennedy ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 165 X

(A) Metastatic carcinoma of lung - Original tumor site unknown

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from March 10 1957 to Dec 6 1967, that (I) (~~we~~) last saw the deceased alive on Dec 4 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Alfred G. Ossman Jr. M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-7-67

23C. PHYSICIAN'S NAME (Type): Alfred G. Ossman, Jr. M.D.

23D. ADDRESS: 1101 St. Paul St.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/9/67

24C. NAME of CEMETERY or CREMATORY: New Cathedral

24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Tankersley

25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co. ADDRESS: 4905 York Road Balto. Md. 21212

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11833 Registered No. 67 11833

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALICE VALLEY CHINLUND

2. DATE AND HOUR OF DEATH: 12-8-67 6:05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-12
D. STREET ADDRESS (If rural, give location): 113 CASTLEWOOD ROAD

5. SEX: FEMALE
6. RACE: CAUCASIAN
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 11-16-11
9. AGE (In years last birthday): 56
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: N.A.
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: LEVI VALLEY
14. MOTHER'S MAIDEN NAME: MARGARET SHARP

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: HOSPITAL ADMISSION HISTORY
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 325 X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~VIRAL PNEUMONIA~~ — 18 DAYS
DUE TO
(B) pulmonary fibrosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

C.G. Yen

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12-7-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: TRACHEOSTOMY - RESP. ARREST
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 30 1967 to DECEMBER 8 1967, that (I) (we) last saw the deceased alive on DECEMBER 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: B. E. Cathey M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-8-67
23C. PHYSICIAN'S NAME (Type): B. E. CATHEY M.D.
23D. ADDRESS: UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/11/67
24C. NAME of CEMETERY or CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Tedrow
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.
ADDRESS: 4905 York Road Balto. Md. 21212

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-6 1/6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11834 Registered No. 67 11834

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ralph A. Garner

2. DATE AND HOUR OF DEATH: December 7, 1967 9:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-01
D. STREET ADDRESS (If rural, give location): 3810 Greenmount Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Married	5-8-1893	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic	Construction	Md.	USA

13. FATHER'S NAME: George Garner

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW1	220-07-1478	Mrs. Evelyn C. Garner	(Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — Immediate

DUE TO

(B) ASCV Disease — 5-6 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 12-7 1967 to 12-7 1967, that (I) (we) last saw the deceased alive on 12-6 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Philip D. Flynn M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-8-67

23C. PHYSICIAN'S NAME (Type): Philip D. Flynn M.D.

23D. ADDRESS: 11 E. Chase St.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	12-11-67	Loudon Park	Baltimore	Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Tankard

25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co. ADDRESS: 4905 York Road Baltimore, Md. 21212

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
C-516

67 11835 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11835

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LEROY E. CHAMBERLAIN

2. DATE AND HOUR PRONOUNCED DEAD: December 10, 1967 1:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Johns Hopkins Hospital (DOA)

33/90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Harford Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Joppatowne 21085 62-00
D. STREET ADDRESS (If rural, give location): 1045 Plaza Circle

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: May 23, 1924
9. AGE (In years last birthday): 43
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inspector
10B. KIND OF BUSINESS OR INDUSTRY: Auto Plant
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin J. Chamberlain
14. MOTHER'S MAIDEN NAME: Marion I. Hagerman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Mildred Chamberlain
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. E812.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Injuries

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Route 40 - ½ mi.E. of Jones Road

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12/10/67 12:38 A.M.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by car 62-00

22. I certify that I held an Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

M.D. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 12/10/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12/13/67.
23C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery
23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
24B. NAME OF REGISTRAR: Robert E. Fairbanks
24C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.
ADDRESS: Balto. Md. 21214

VS 151-REV. 1/1/65

N869.2

1
P-613

67 11836

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11836

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): C. M. JOSEPHINE PRIVITERA

2. DATE AND HOUR PRONOUNCED DEAD: December 10, 1967 | 8:14 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Union Memorial Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21206 27-01
D. STREET ADDRESS (If rural, give location): 4004 Southern Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Widow	Feb. 15, 1917.	50				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Saleslady	Cosmetics	Maryland	USA

13. FATHER'S NAME: Joseph Vetri

14. MOTHER'S MAIDEN NAME: Frances P. Balbo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-09-4465

17. INFORMANT: Mr. Joseph Privitera

ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 443X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 11, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/15/67.	Holy Redeemer Cemetery	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 11 1967	Robert E. Fellows	Leonard J. Ruck, Inc.	Balto. Md. 21214

VS 151-REV. 1/1/65

1
C-633

67 11837 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11837

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARIE K. CREDITO

2. DATE AND HOUR PRONOUNCED DEAD: December 7, 1967 | 7:55 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21206 26-02
D. STREET ADDRESS (If rural, give location): 4303 Cook Ave.

5. SEX: Female
6. RACE: Whitet
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: May 17, 1922.
9. AGE (In years last birthday): 45
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Krisher
14. MOTHER'S MAIDEN NAME: Marie Welteroth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W W 2
16. SOCIAL SECURITY NO.: 177-12-2697
17. INFORMANT: Mr. Carmen Credito
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple traumatic injuries

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

8 16.4

19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Frankford and Walther Blvd. 27-34

21D. TIME OF INJURY (APPROX.) (Month) 12 (Day) 7 (Year) 67 (Hour) 7:30p m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Subject driver in auto-auto coll.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [XX]
ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 8, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12/12/67.
23C. NAME of CEMETERY or CREMATORY: Baltimore National Cem.
23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
24B. NAME OF REGISTRAR: Robert E. Fulkerson
24C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS

VS 151-REV. 1/1/65

N869.2

E-65

67 11838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11838

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CYRIL V. ERNI SR.

2. DATE AND HOUR OF DEATH: 12-8-67 | 8.15 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

2738

D. STREET ADDRESS (If rural, give location): 1809 RAMBLEWOOD ROAD 21214

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 7-10-05

9. AGE (In years last birthday): 62

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Major (USAF)

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: EMIL ERNI

14. MOTHER'S MAIDEN NAME: Maybelle ~~MABEL~~ CRAIG

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes

(If yes, give war or dates of service): W W 2

16. SOCIAL SECURITY NO.: 215-30-3787

17. INFORMANT: Mrs. Alice A. Erni

ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 4-5 / X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(1) (2)

(A) RENAL FAILURE & PERITONITIS

DUE TO

2° TO INFARCTED & NECROTIC (R) COLON & TERMINAL ILEUM

(B)

DUE TO

(C) PROBABLY EMBOLI FROM THORACIC AORTIC ANEURYSM

INTERVAL BETWEEN ONSET AND DEATH: ABOUT 3-5 DAYS

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

PROBABLE PNEUMONIA & SEPSIS

19A. DATE OF OPERATION: 11/27 & 12/5

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: (1) THORACIC AORTIC ANEURYSM; (2) BOWEL INFARCTION

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/27 19 67 to 12/8 19 67, that (I) (we) last saw the deceased alive on 12/8/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Mark B. Orringer M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/8/67

23C. PHYSICIAN'S NAME (Type): MARK B. ORRINGER M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/12/67.

24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Hankey M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md.

ADDRESS: 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

16 97 15 AS ERNI, CYRIL V.

m-350

67 11839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11839

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROY A. MATHENY

2. DATE AND HOUR OF DEATH: DECEMBER 9, 1967 | 5 00 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21211 13-07

D. STREET ADDRESS (If rural, give location): 826 UNION AVENUE

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 9/19/1887

9. AGE (In years last birthday): 80

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY: (Hope Gas Co.)

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES L. MATHENY

14. MOTHER'S MAIDEN NAME: MATHILDA MOORE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Unk.

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Mrs. N. Olive Matheby

ADDRESS: (Same)

MEDICAL CERTIFICATION

I

1B. 3324

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Cerebral thrombosis

DUE TO L middle cerebral artery

(B)

DUE TO Pulmonary edema

(C)

INTERVAL BETWEEN ONSET AND DEATH: 4 days.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DECEMBER 5 1967 to DECEMBER 9 1967, that (I) (we) last saw the deceased alive on DECEMBER 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Nieva G. Valle M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: Dec. 9, 1967

23C. PHYSICIAN'S NAME (Type): NIEVA G. VALLE M.D.

NIEVA G. VALLE

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/12/67.

24C. NAME of CEMETERY or CREMATORY: Copelin Cemetery

24D. LOCATION (City, town, or county) (State): Harrison Co. W. Va.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Tankey M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.

ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Bridal Attendants

W-553 1

BIRTH NO. 67 11840

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11840

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Thomas J. Winand, Jr.

2. DATE AND HOUR OF DEATH: Dec. 8, 1967 | 11:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 2705 Beechland Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21214 27-06

D. STREET ADDRESS (If rural, give location): 2705 Beechland Avenue

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Jan. 18, 1902

9. AGE (In years last birthday): 65

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Accountant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Winand

14. MOTHER'S MAIDEN NAME: Gertrude Nevine

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-09-8373

17. INFORMANT: Mrs. Marian Winand

ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 443 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive CVD — INTERVAL BETWEEN ONSET AND DEATH: 10 years

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from 19 56 to Dec. 8 1967, that (I) ~~(we)~~ last saw the deceased alive on Dec. 5, 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: R Donald Jandorf M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-9-67

23C. PHYSICIAN'S NAME (Type): R Donald Jandorf M.D.

23D. ADDRESS: 6077 Harford Rd

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/12/67

24C. NAME of CEMETERY or CREMATORY: Gardens Of Faith

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Fosbury M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.

ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

D-120

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11841

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11841

1. NAME OF DECEASED (Type or Print): Floyd C. Davis

2. DATE AND HOUR OF DEATH: Dec. 8, 1967. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 2059 E. Belvedere Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 27-38
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21214
D. STREET ADDRESS (If rural, give location): 2059 E. Belvedere Ave.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Apr. 16, 1905.
9. AGE (In years last birthday): 62
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self-Employed
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Millard Davis
14. MOTHER'S MAIDEN NAME: Elizabeth Snell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-10-9295
17. INFORMANT: Mrs. Sadie M. Davis
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. 163X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Carcinoma of the Lung — 5 months
DUE TO
(B) Metastasis to mediastinum — 1 month
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Previous Myocardial Infarction

19A. DATE OF OPERATION: 9/15/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinoma of Lung
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from August 28 1967 to December 1967, that (I) ~~(we)~~ last saw the deceased alive on December 5 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) (We) ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: Robert J. Wilder M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/11/67
23C. PHYSICIAN'S NAME (Type): ROBERT J. WILDER M.D.
23D. ADDRESS: 1801 Eutaw Pl. Baltimore, Md. 21217

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/12/67.
24C. NAME of CEMETERY or CREMATORY: Dulaney Valley Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Falkenham
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md.
ADDRESS: 21214

VS 150-REV. 1/1/65

R-226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11842 Registered No. 67 11842

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ruzicka, Miss Caroline L.

2. DATE AND HOUR OF DEATH: 12/10/67 | 4:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

1617 Chilton St.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, Maryland 21218

D. STREET ADDRESS (If rural, give location)

906

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	NEVER MARRIED	3/3/94	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
~~XXXXXXXXX~~ Ret.	Hochschild Kohn & Co.	MARYLAND	USA

13. FATHER'S NAME: FRANK RUZICKA

14. MOTHER'S MAIDEN NAME: Barbara Slama

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Richard F. Ruzicka

ADDRESS

MEDICAL CERTIFICATION

1B. 330 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Subarachnoid hemorrhage — 2 days

DUE TO

(B) Hypertension — years

DUE TO

Idiopathic

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ATRIAL FIBRILLATION

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0	—		

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
—	—	—

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
—	While At Work ☐ Not While At Work ☐	—

22. I certify that (I) (this hospital) attended the deceased from 12/8 19 67 to 12/10 19 67, that (I) (we) last saw the deceased alive on 12/10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C. E. McFalls M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 10 Dec '67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/13/67	Moreland Memorial Park	Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 11 1967	Robert E. Falkenna	Leonard J. Ruck Inc.	Balto. Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-2601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

67 11843

Registered No. 67 11843

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HEISER, JOHN W. SR.

2. DATE AND HOUR OF DEATH: 12/10/67 | 11:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY:

C. CITY OR TOWN: Balto (If outside city limits, write RURAL and give township) 21214

D. STREET ADDRESS (If rural, give location): 5001 Roxo Road

2703

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 9/24/01

9. AGE (In years last birthday): 66

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired (Purchasing Agent)

10B. KIND OF BUSINESS OR INDUSTRY: (A.&P.)

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: milton Heiser

14. MOTHER'S MAIDEN NAME: ~~[illegible]~~ HARRIETT SpECHT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 207-09-1336

17. INFORMANT: MRS. BETTY HEISER

ADDRESS: (SAME)

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Acute myocardial infarct.

DUE TO

(B) Coronary insufficiency

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/10/ 19 67 to 12/10/ 19 67, that (I) (we) last saw the deceased alive on 12/10/ 19 67 and that ~~(I am)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: T. Limpanuchara M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/10/67

23C. PHYSICIAN'S NAME (Type): T. LIMPANUCHARA M.D.

23D. ADDRESS: Union Memorial Hosp

24A. BURIAL CREMATION, REMOVAL (Specify): Entombment

24B. DATE: 12/13/67.

24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Mausoleum

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.

ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-2401

67 11844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11844

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SIEGLE MR HARRY M.

2. DATE AND HOUR OF DEATH: 12-11-67 / 6.15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME AND HOSPITAL 100 N. BROADWAY, BALTO, MD.

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD

B. COUNTY: 27-05

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 3023 N. WAY DR. (34) Northway Drive

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 11-23-1887

9. AGE (In years last birthday): 80

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction Worker

10B. KIND OF BUSINESS OR INDUSTRY: RETIRED.

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John M. Siegle

14. MOTHER'S MAIDEN NAME: Caroline Ruff

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-32-9277

17. INFORMANT: Mrs. Pearle T. Siegle

ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

334 X

(A) Congestive Failure

DUE TO

(B) Generalized Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral Arteriosclerosis

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this ~~hospital~~) attended the deceased from 12/6 1967 to 12/11 1967, that (I) (we) last saw the deceased alive on 12/11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/11/67

23C. PHYSICIAN'S NAME (Type): NENITA SUAREZ M.D.

23D. ADDRESS: Church Home & Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/14/67.

24C. NAME of CEMETERY or CREMATORY: Baltimore Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Tankersley

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-4321

BIRTH NO. 67 11845

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11845

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): EDNA GLADSTONE

2. DATE AND HOUR OF DEATH: 12-10-67 | 11:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 MARYLAND GENERAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: —
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21234 21-48
D. STREET ADDRESS (If rural, give location): 6106 Parkway Drive

5. SEX: Female
6. RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: 4-7-13
9. AGE (In years last birthday): 54
If Under 1 Yr. Months: — Days: — If Under 24 Hrs. Hours: — Min.: —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Biller
10B. KIND OF BUSINESS OR INDUSTRY: Hecht Bros
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Percy Gladstone
14. MOTHER'S MAIDEN NAME: Mary Green

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 212-09-9113
17. INFORMANT: Rev. Chart
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhagic Shock — ~~Days~~ Hrs.
DUE TO
(B) Bleeding from Esophageal Varices — Days
DUE TO
(C) Cirrhosis of the Liver — Years

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: None
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): —
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH ~~(notify medical examiner)~~: No
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ ~~Not While At Work~~ ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 11/25 19 67 to 12-10 19 67, that (I) (~~we~~) last saw the deceased alive on 12-10 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: C. E. DeFelice M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-10-67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS: Maryland General Hospita l

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/14/67.
24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Fankuna
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.
ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

B-6251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11846 Registered No. 67 11846

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ESTHER A. BURGAN

2. DATE AND HOUR OF DEATH: DECEMBER 8, 1967 2 30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE ~~BALTIMORE~~ B. COUNTY MARYLAND
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 4905 ARABIA AVENUE

27-03

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, ~~DIVORCED~~ (specify): NEVER MARRIED
8. DATE OF BIRTH: NOV. 9, 1902
9. AGE (In years last birthday): 65
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Maker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND ~~EDNA JONES~~
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HARRY BURGAN
14. MOTHER'S MAIDEN NAME: EDNA JONES

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Miss Ruth E Burgan ADDRESS: Same

MEDICAL CERTIFICATION

18. 330X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) DUE TO: Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
(B) DUE TO:
(C):

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/7 1967 to 12/8 1967, that (I) (we) last saw the deceased alive on 12/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Nieva G. Valle M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: Dec 8, 1967
23C. PHYSICIAN'S NAME (Type): NIEVA G. VALLE M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/11/67
24C. NAME of CEMETERY or CREMATORY: Baltimore
24D. LOCATION (City, town, or county) (State): Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Farley
25C. FUNERAL DIRECTOR: Leonard J Ruck Inc. ADDRESS: 5305 Harford Rd

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Subsequent transfer

Sent to file

RIEVA G. VALLE

L-520

67 11847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11847

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Frank J. Long

2. DATE AND HOUR OF DEATH: December 8, 1967 | 10:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4524 Mainfield Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-02

D. STREET ADDRESS (If rural, give location): 4524 Mainfield Ave.

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced

8. DATE OF BIRTH: April 17, 1888

9. AGE (In years last birthday): 79

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Electrician

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Long

14. MOTHER'S MAIDEN NAME: Mary A. Garrett

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 705098130A

17. INFORMANT: Mrs Virginia Lusco

ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Generalized Arteriosclerosis — 10 years

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Residual Hemiplegia — 10 years

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from August 2 1967 to Dec 8 1967, that (I) (we) last saw the deceased alive on Dec 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: George Sawyer, M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/8/67

23C. PHYSICIAN'S NAME (Type): GEORGE SAWYER - M.D.

23D. ADDRESS: 4808 Harford Rd. Balto. Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 12/11/67

24C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Foxberg M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc

ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-63

BIRTH NO. 67 11848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11848

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Marguerita L Hardy

2. DATE AND HOUR OF DEATH: 12-8-67 2 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Balt Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 6911 Dunmanway

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 6-29-96
9. AGE (In years last birthday): 71 — If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Frank ~~Kabark~~ La Barzer
14. MOTHER'S MAIDEN NAME: Mattie Foxwell
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213 28 4786
17. INFORMANT: Raymond F Hardy — ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 154 X

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic carcinoma — 18 mos

DUE TO

(B) Carcinoma of the

DUE TO

(C) Rectum

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: [redacted]
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-17 1967 to 12-8 1967. that (I) (we) last saw the deceased alive on 12-8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: F. A. Baltazar Jr. M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/8/67
23C. PHYSICIAN'S NAME (Type): FRANCISCO BALTAZAR M.D.
23D. ADDRESS: Church Home + Hosp Baltimore Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/11/67
24C. NAME of CEMETERY or CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Faskyma
25C. FUNERAL DIRECTOR: Leonard J Ruck Inc — ADDRESS: 5305 Harford Rd

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-30

BIRTH NO. 67 11849

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11849

1. NAME OF DECEASED (Type or Print): Henry W. Schuette

2. DATE AND HOUR OF DEATH: December 7, 1967 | 10:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): House In The Pines Nursing Home 5837 Belair Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-01

D. STREET ADDRESS (If rural, give location): 667 Dumbarton Ave.

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: Aug. 12, 1893

9. AGE (In years last birthday): 74

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Postal Clerk

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ferdinand Schuette

14. MOTHER'S MAIDEN NAME: Emilie Birr

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-44-9856 I

17. INFORMANT: Frank Kohl

ADDRESS: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary emphysema — 10 yrs.

DUE TO

(B) Arteriosclerotic cardio-vascular disease — 15 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from January 17, 1966 to December 7, 1967, that (I) (~~we~~) last saw the deceased alive on December 6, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Lloyd E. Saylor M.D.

Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Dec. 8, 1967

23C. PHYSICIAN'S NAME (Type): Lloyd E. Saylor M.D.

23D. ADDRESS: 3902 Greenmount Avenue

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 12-11-67

24C. NAME of CEMETERY or CREMATORY: Baltimore Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc

ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-251a

BIRTH NO. 67 11850

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11850

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Julia E. Washington

2. DATE AND HOUR OF DEATH: 12-5-67 | 3:50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1206 Whitelock Street

13-03

5. SEX: F.
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 4-6-1902
9. AGE (In years last birthday): 65
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): Maryland, HOWARD CO.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: AMOS DORSEY
14. MOTHER'S MAIDEN NAME: HANNAH DORSEY
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-09-1804
17. INFORMANT: William - Husband
ADDRESS: SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
18. 434.1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 3, 19 67 to December 5, 19 67, that (I) (we) last saw the deceased alive on December 5, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Laredo M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-6-67
23C. PHYSICIAN'S NAME (Type): Dr. C. Laredo M.D.
23D. ADDRESS: L514 Division Street Balt., Maryland

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-9-67
24C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Pk.
24D. LOCATION (City, town, or county) (State): Arbutus, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967
25B. NAME OF REGISTRAR: Robert E. Lerley M.D.
25C. FUNERAL DIRECTOR: MORTON & DYETT F.H.
ADDRESS: 1701 Laurens St

VS 150-REV. 1/1/65

J-67 35

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11851 Registered No. 67 11851

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EDITH E. JORDAN

2. DATE AND HOUR OF DEATH: 12-9-67 8:55 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2737 E. PRESTON ST

8-03

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	NEGROID	MARRIED	3-24-1911	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	Home	Isle of White Cy, Va.	U.S.A.

13. FATHER'S NAME: JAMES WILSON

14. MOTHER'S MAIDEN NAME: LILLY LIGGINS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Noel Jordan ADDRESS: 2737 E. Preston

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 153.8 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF COLON — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-2 1967 to 12-9 1967, that (I) (we) last saw the deceased alive on 12-9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Major W. Bradshaw M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-9-67

23C. PHYSICIAN'S NAME (Type): MAJOR W. BRADSHAW M.D.

23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12-13-67	Jones Grove Bapt. Ch. Cem.	Smithfield, Va.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 11 1967	[illegible]	Morton & Dyett Fun.	1701 Lanvale

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-500

67 11852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11852

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARY F WINN

2. DATE AND HOUR OF DEATH: 12-10-67 6:40 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD

B. COUNTY:

C. CITY OR TOWN: Balto (If outside city limits, write RURAL and give township) 16-05

D. STREET ADDRESS (If rural, give location): 1019 N. Bentalou St

5. SEX: F

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): W

8. DATE OF BIRTH: 12-25-1884

9. AGE (In years last birthday): 82

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Essex Co, Va.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: UNK.

14. MOTHER'S MAIDEN NAME: Susan Carter

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Garnetta Goode ADDRESS: 370 Elton St. N.Y.

MEDICAL CERTIFICATION

1B. 153.81

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardiac arrest 2° to ~~[illegible]~~ MI —

DUE TO

(B) ACUTE PULM EDEMA 2° MI 12 hrs.

DUE TO

(C) ADENOCARCINOMA OF COLON, ASCND - 5 yrs & >20 yrs respectively

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 1 19 67 to Dec 10 19 67, that (I) (we) last saw the deceased alive on 6:40 AM 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A S Glushakow M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): A S GLUSHAKOW M.D.

23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-14-67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 11 1967

25B. NAME OF REGISTRAR: Robert E. Fankenna

25C. FUNERAL DIRECTOR: Morton & Dyett F.H.

ADDRESS: 1201 Lakewood

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

m-324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11853

Registered No. 67 11853

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mitchell, Virginia L.

2. DATE AND HOUR OF DEATH: 12/6/67 11 30 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1718 W. Lafayette Ave. #17 1603

5. SEX: Female
6. RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 11/17/21
9. AGE (In years last birthday): 46
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Nettie Kane

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: James A. Mitchell — ADDRESS: Same

MEDICAL CERTIFICATION

18. 214 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Brain Abscess — 1 wk

DUE TO

(B) Peritonitis — 10 days

DUE TO

(C) Post-op Bleeding — 14 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 14 Nov
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: L. Broad - T-O Abscess
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 30 Oct 1967 to 6 Dec 1967, that (I) ~~(we)~~ last saw the deceased alive on 6 Dec 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We) (did)~~ (did not) view the body after death.

23A. SIGNATURE: Richard Berkowitz M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 7 Dec 67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-12-67
24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery
24D. LOCATION (City, town, or county) (State): Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Lindsay
25C. FUNERAL DIRECTOR: Arlington A. Phillips
ADDRESS: 1727 N. Monroe St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11854 Registered No. 67 11854

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Amy Barnes

2. DATE AND HOUR OF DEATH: December 3, 1967 | 12:45 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1132 W. Lexington Street Baltimore, Maryland 21223

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 18-02
D. STREET ADDRESS (If rural, give location): 1132 W. Lexington Street

5. SEX: Female
6. RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 11-19-1910
9. AGE (In years last birthday): 57
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Alabama
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Williams
14. MOTHER'S MAIDEN NAME: Emma M.N. Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-20-5661
17. INFORMANT: Rev. Joseph Barnes
ADDRESS: 1132 W. Lexington St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 450.0

(A) DUE TO: Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

(B) DUE TO:

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-12-1967 to 12-3-1967, that (I) (we) last saw the deceased alive on 12-2-1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Percival C. Smith M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12-5-67
23C. PHYSICIAN'S NAME (Type): Percival C. Smith M.D.
23D. ADDRESS: 1709 Gwynns Falls Pkwy.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-7-67
24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Fackenthal
25C. FUNERAL DIRECTOR: Arlington S. Phillips
ADDRESS: 1727 N. Monroe Street

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

SAB-50-66-51

B-400

BIRTH NO.

M.E. CASE NO. 67 11855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11855

1. NAME OF DECEASED (Type or Print): BAILEY AUGUSTUS

2. DATE AND HOUR OF DEATH: 12/7/67 2:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

19-01

D. STREET ADDRESS (If rural, give location): 1315 West Mulberry Street 21223

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widower

8. DATE OF BIRTH: 1-31-1897

9. AGE (In years last birthday): 70

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John W. Bailey

14. MOTHER'S MAIDEN NAME: (MN) Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-07-4090

17. INFORMANT: Records: BCH-4940 Eastern Avenue

ADDRESS: 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 570.3 I 260 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) VOLVULUS OF SIGMOID. — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS.

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) CARDIAC ARREST

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELITUS — HYPERTENTION

19A. DATE OF OPERATION: 12/6/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: INTESTINAL OBSTRUCTION

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 11/30 19 67 to 12/7 19 67, that (I) (we) last saw the deceased alive on 12/7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/7/67

23C. PHYSICIAN'S NAME (Type): Enrique Castro ENRIQUE CASTRO M.D.

23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Md. BALTIMORE CITY HOSPITALS 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-11-67

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Fankenna

25C. FUNERAL DIRECTOR: Arlington S. Phillips

ADDRESS: 1727 N. Monroe St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-4621

67 11856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11856

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARGARET M. CLARK

2. DATE AND HOUR OF DEATH: 12-7-67 | 9:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL

37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: ~~BA~~ MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 12-02

D. STREET ADDRESS (If rural, give location): 3322 GREEN MOUNT AVE.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE

8. DATE OF BIRTH: 10-13-94

9. AGE (In years last birthday): 73

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY: Goverment

11. BIRTHPLACE (State or foreign country): BALTIMORE

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: JAMES B. CLARK

14. MOTHER'S MAIDEN NAME: MARGARET HAMIL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Family records

ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

1B. 148X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ELECTROLYTE IMBALANCE ?

DUE TO

(B) DEHYDRATION ?

DUE TO

(C) CA PHARYNX W/ METASTASIS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: DONE

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-4 1967 to 12-7 1967, that (I) (we) last saw the deceased alive on 12-7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Samuel A. Torres M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-7-67

23C. PHYSICIAN'S NAME (Type): SAMUEL A. TORRES M.D.

23D. ADDRESS: MERCY HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/11/67

24C. NAME of CEMETERY or CREMATORY: New Catheeral Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Tankersley

25C. FUNERAL DIRECTOR: C.F. EVANS & SON

ADDRESS: 8802 Harford road

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

SAB-31-34-92

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B-356 67 11857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11857

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BITTNER MARIE

2. DATE AND HOUR OF DEATH: 6 December 1967 6 15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: Baltimore City Hospitals

(If not in hospital or institution, give street address or location): 4940 Eastern Avenue, Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

26-08

D. STREET ADDRESS (If rural, give location): 243 South Highland Avenue 21224

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 8-16-1890

9. AGE (In years last birthday): 77

(If Under 1 Yr. Months Days) (If Under 24 Hrs. Hours Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNK.

14. MOTHER'S MAIDEN NAME: UNK.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO. A 216-09-7432

17. INFORMANT: Records: BCH-4940 Eastern Avenue

ADDRESS: 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ASPIRATION PNEUMONITIS

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

491 X

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. REFRACTORY ANEMIA

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8 November 1967 to 6 December 1967, that (I) (we) last saw the deceased alive on 6 December 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Melvyn S. Tockman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 6 December 1967

23C. PHYSICIAN'S NAME (Type): Melvyn S. Tockman M.D.

23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): 12/9/67

24B. DATE: Burial

24C. NAME of CEMETERY or CREMATORY: Mt. Carmel Cem

24D. LOCATION (City, town, or county) (State): Balto. Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Foley

25C. FUNERAL DIRECTOR: Joseph N. Zommers

ADDRESS: 263 S. Collington St.

VS 150-REV. 11/66

1

S-166

67 11858

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11858

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANSELM SPURRIER

2. DATE AND HOUR PRONOUNCED DEAD: December 8, 1967 | 7:45 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 702 N. Howard St. D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-03
D. STREET ADDRESS (If rural, give location): 702 N. Howard St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Single	April 12, 1899	68				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Store	Balto. Md.	U. S. A.

13. FATHER'S NAME: Walter D. Spurrier

14. MOTHER'S MAIDEN NAME: Anna Malome

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-05-8997

17. INFORMANT: Mrs. J. Alban Eagers ADDRESS: Balto. Md. 21212 4503 Underwood Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 493X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PNeumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Partial	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ P Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 8, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	Dec. 10, 1967	New Cathedral Cem.	Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 12 1967	Robert E. Farley M.D.	G. Truman Schwab	3512 Frederick Ave. Balto. Md.

VS 151-REV. 1/1/65

B-532 1

BIRTH NO. 67 11859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11859

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Helen Marie Bentz

2. DATE AND HOUR OF DEATH: December 9, 1967 | 1:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. South Baltimore General Hospital

43/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21230 23-03

D. STREET ADDRESS (If rural, give location): 1800 S. Charles Street

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Sept. 22, 1908

9. AGE (In years last birthday): 59 years

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator

10B. KIND OF BUSINESS OR INDUSTRY: Hoffman Awning Co.

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Brandt

14. MOTHER'S MAIDEN NAME: Elizabeth Raum

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Leroy Bentz

ADDRESS: 1800 S. Charles St. 21230

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

420.1

(A) Coronary occlusion. — INTERVAL BETWEEN ONSET AND DEATH: D.O.A.

DUE TO

(B) Hypertensive C.V. Disease — 15 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1954 19 to 12/9/67 19 S, that (I) (we) last saw the deceased alive on 11/20/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Pt. D.O.A. SS-818 — S. Ellison M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/11/67

23C. PHYSICIAN'S NAME (Type): E. S. ELLISON M.D.

23D. ADDRESS: 107 E. West St. Bel Air, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/13/67

24C. NAME of CEMETERY or CREMATORY: Cedar Hill Cemetery

24D. LOCATION (City, town, or county) (State): Anne Arundel Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: McCully F. H.

ADDRESS: 130 E. Fort Ave. 21230

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-35 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11860 Registered No. 67 11860

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HEDIAN, Ralph Victor

2. DATE AND HOUR OF DEATH: December 10, 1967 | 3:45 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Blvd., Baltimore, Maryland 21218

27

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 316 E. 33rd St.

12-02

5. SEX: Male
6. RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 1-31-94
9. AGE (In years last birthday): 73
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Policeman
10B. KIND OF BUSINESS OR INDUSTRY: Police Force
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Alfred M. Hedian
14. MOTHER'S MAIDEN NAME: Ella V. Haley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): 4-20-17 to 8-13-19
16. SOCIAL SECURITY NO.: 215-22-37-02
17. INFORMANT: Records
ADDRESS: V. A. Hospital, Baltimore, Maryland 21218

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 570.21

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 24 Hours

DUE TO

(B) Gangrene Of Small Bowel — 24 Hours

DUE TO

(C) Superior Mesenteric Artery Embolus — 36 Hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that XX (this hospital) attended the deceased from November 24, 1967 to December 10, 1967, that X (we) last saw the deceased alive on December 10, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) (did not) view the body after death.

23A. SIGNATURE: John L. Cameron M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X
23B. DATE SIGNED: 12/10/67
23C. PHYSICIAN'S NAME (Type): John L. Cameron M.D.
23D. ADDRESS: Veterans Administration Hospital, Balto., Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/13/1967
24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Eugenia K. Seitz
ADDRESS: 5209 York Rd. Seitz Funeral Home Balto. Md. 21212

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-624-1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11861 Registered No. 67 11861

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CLYDE FAIRCLOTH

2. DATE AND HOUR OF DEATH: 12-9-67 7:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 31 ~~XXXX~~ CITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-10

D. STREET ADDRESS (If rural, give location): 26 S. Highland Avenue

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 3-17-97

9. AGE (In years last birthday): 70

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY: TEXTILE

11. BIRTHPLACE (State or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: BLACKMAN FAIRCLOTH

14. MOTHER'S MAIDEN NAME: LIZZIE GILES

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: LACY BRACH, ROSEBORO, N.C. ADDRESS:

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 443 X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) ARTERIOSCLEROTIC HEART DIS — 5 YRS

DUE TO

(B) HYPERTENSIVE HEART DIS — 5 YRS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 14 1962 to Oct 21 1967, that (I) (we) last saw the deceased alive on October 21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Irvin B. Kaplan M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-10-67

23C. PHYSICIAN'S NAME (Type): IRVIN B. KAPLAN M.D.

23D. ADDRESS: 129 S. BROADWAY

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12-13-67

24C. NAME of CEMETERY or CREMATORY: ROSEBORO CEMETERY

24D. LOCATION (City, town, or county) (State): SAMPSON CO., NORTH CAROLINA

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Foulkrod

25C. FUNERAL DIRECTOR: HOWARD H. HUBBARD ADDRESS: 4107 WILKENS AVE. 21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11862 Registered No. 67 11862

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Connolly, Mr. Nelson J.

2. DATE AND HOUR OF DEATH: 12-10-67 3:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secour Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 64 S. Carrollton Ave.

18-03

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Single	7-29-92	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RR retirement	B. & O. R.R.	Maryland	U.S.A.

13. FATHER'S NAME: Michael Connolly

14. MOTHER'S MAIDEN NAME: Catherine McKewin

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	✓	Robert Hall	1018 Rockhill Ave (21229)

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 465 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) 1- Cor pulmonale.

DUE TO

(B) Pulmonary Thrombo-embolism (probably.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-9-67 19 to 12-10/67 3.40 P.m. 19, that (I) (we) last saw the deceased alive on 3.40. 12-10-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Mohamad M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-10-67

23C. PHYSICIAN'S NAME (Type): Mohamad M.D.

23D. ADDRESS: Bon Secours Hosp. Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	12/13/67	New Cathedral Cem.	4300 Old Frederick Rd	Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 12 1967	Robert E. Lehman	John J. Cowardson Inc.	2 Collins St. 23, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-1651

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11863 Registered No. 67 11863

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM R. O'BRIEN

2. DATE AND HOUR OF DEATH: December 7, 1967 8-45 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Anne Arundel Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Glen Burnie 52-00
D. STREET ADDRESS (If rural, give location): 1138 McHenry Dr., Arundel Hills

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	Jan. 30, 1900	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Plasterer	Construction	New York, N. Y.	U.S.

13. FATHER'S NAME: James O'Brien

14. MOTHER'S MAIDEN NAME: Catherine Bolger

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 114-07-7383

17. INFORMANT: Marie O'Brien - 1138 McHenry Dr., Glen Burnie ADDRESS

MEDICAL CERTIFICATION

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1

(A) Coronary occlusion — 20y-
DUE TO
(B) Coronary thrombosis
DUE TO
(C) Coronary atherosclerosis

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: none

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		no	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 20 1950 to Nov. 27 1967, that (I) (we) last saw the deceased alive on Nov. 27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Imre Neubauer M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: December 8, 1967

23C. PHYSICIAN'S NAME (Type): Imre Neubauer M.D.

23D. ADDRESS: 936 Patapsco Ave., Baltimore, Md. 21225

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12-11-1967	Glen Haven Memorial Park	Ritchie Hgwy., A.A.Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 12 1967	Robert E. Fankuna	George J. Gonce	4001 Ritchie Hgwy., Baltimore

VS 150-REV. 1/1/65

I-6501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11864 Registered No. 67 11864

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): R. Margaret Irwin

2. DATE AND HOUR OF DEATH: 12/9/67 3:10 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 SOUTH BALTIMORE GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: 25-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 3703 Sixth Street

5. SEX: Femald 6. RACE: White 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widow 8. DATE OF BIRTH: 4/22/83 9. AGE (In years last birthday): 84 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Houck 14. MOTHER'S MAIDEN NAME: Mary Duggan

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: Mrs. Margaret Kallas -Rt. 3, Box 313, Arnold, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) ASCVD

DUE TO

(B) Acute M. Infarction — 1 week

DUE TO

(C) Rupture of Myocardium & Hemopericardium — 1 hour?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia

19A. DATE OF OPERATION: 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from 12/2/67 19 to 12/9/67 19, that (X) (we) last saw the deceased alive on 12/9/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Colvin C. Carter M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. XX

23B. DATE SIGNED: 12/9/67

23C. PHYSICIAN'S NAME (Type): Colvin C. Carter M.D.

23D. ADDRESS: S.B.G.H. - 1213 Light Street

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 12-12-1967 24C. NAME of CEMETERY or CREMATORY: Holy Cross Cemetery 24D. LOCATION (City, town, or county) (State): Ritchie Hgwy., A.A.Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967 25B. NAME OF REGISTRAR: Robert E. Tarkington 25C. FUNERAL DIRECTOR: George J. Gence 25D. ADDRESS: 4001 Ritchie Hgwy., Baltimore

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

K-536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11865 Registered No. 67 11865

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CASIMIR C. KENDRYNA

2. DATE AND HOUR OF DEATH: December 10, 1967 | 5:25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 3308 Moravia Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-01

D. STREET ADDRESS (If rural, give location): 3308 Moravia Road

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 2/3/1885

9. AGE (In years last birthday): 82

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butcher

10B. KIND OF BUSINESS OR INDUSTRY: Meat Packing

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? Poland

13. FATHER'S NAME: John Kendryna

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): –

16. (If yes, give war or dates of service): –

SOCIAL SECURITY NO. 328-18-5719

17. INFORMANT: Mr. Thaddeus Kendryna

ADDRESS: 3308 Moravia Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

18. 4222

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Cardiac Insufficiency	10 days
DUE TO (B)	Chronic Myocarditis	5 yrs.
DUE TO (C)		

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 10 1960 to Dec. 10 1967, that (I) (we) last saw the deceased alive on Dec. 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John V. Sczerbicki M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-11-67

23C. PHYSICIAN'S NAME (Type): John V. Sczerbicki M.D.

23D. ADDRESS: 1802 Eastern Avenue

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/13/67

24C. NAME of CEMETERY or CREMATORY: Holy Cross

24D. LOCATION (City, town or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR: M.F. SADOWSKI & SONS

ADDRESS: 1808 EASTERN AVE

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
C-235

67 11866 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 11866

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MAURICE D. COSTIN Sr.

2. DATE AND HOUR PRONOUNCED DEAD: December 10, 1967 | 7:05 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 2324 Sidney St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-33
D. STREET ADDRESS (If rural, give location): 2324 Sidney ~~St.~~ AVE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	MARRIED	NOV. 13, 1895	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MOULDER	IRON FOUNDRY	MARYLAND	U.S.A.

13. FATHER'S NAME: JAMES M. COSTIN

14. MOTHER'S MAIDEN NAME: MATILDA ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WORLD WAR I	213-10-7241 B2	Robt. W. Costin	2324 Sidney AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) 422.1 Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

II. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Edward F. Wilson M.D. — Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: December 11, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	12-13-67	BALTIMORE NATIONAL	BALTIMORE, Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 12 1967	Robert E. Farley M.D.	GEO. L. Schwab Funeral Home Francis W. Miller	2101 Frederick Ave.

VS 151-REV. 1/1/65

B-620

THE BODY OF HOBART BURCH WAS RELEASED BY DOCTOR PALMINO OF THE MEDICAL EXAMINERS OFFICE AS **FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11867 Registered No. 67 11867

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BURCH M.D., HOBART A

2. DATE AND HOUR OF DEATH: DECEMBER 8, 1967 10:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital, Baltimore, Maryland 21205 — 33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: NEW YORK B. COUNTY: U.S.A.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ELMIRA — V-29
D. STREET ADDRESS (If rural, give location): 825 W. WATER STREET

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: Aug 18, 1904
9. AGE (In years last birthday): 63 yrs. — If Under 1 Yr. Months / Days / Hours / If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): M.D. (Radiologist)
10B. KIND OF BUSINESS OR INDUSTRY: Radiologist.
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN HENRY BURCH
14. MOTHER'S MAIDEN NAME: CORNELIA S. BRIGGS
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Rev. Hobart A. Burch — ADDRESS: Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 420.1 — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Acute Massive Coronary Thrombosis. — Instant (Sudden).

(B) DUE TO:

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: 10 Hours post operative – Left Sub-occipital Craniectomy & Excision of Acoustic Neuroma. — 9.

19A. DATE OF OPERATION: 12/8/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Left Acoustic Neuroma
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 11/30/ 1967 to 12/8/ 1967, that (I) (~~we~~) last saw the deceased alive on 12/8/ 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Chhabi Bhushan M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/8/67
23C. PHYSICIAN'S NAME (Type): CHHABI BHUSHAN M.D.
23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL, BALTIMORE 5, MD

24A. BURIAL ~~CREMATION~~, REMOVAL (Specify): Transportation FUNERAL COACH
24B. DATE OF FUNERAL: 12/12/67
24C. NAME of CEMETERY or CREMATORY: Forest Lawn Cemetery
24D. LOCATION (City, town, or county) (State): Elmira, New York

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Farber, M.D.
25C. FUNERAL DIRECTOR: Easton Funeral Home — ADDRESS: Catonsville, Md.

VS 150-REV. 1/1/65

R-200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11868 Registered No. 67 11868

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RUBY WOODSON ROSE

2. DATE AND HOUR OF DEATH: 3:50 pm 9 Dec 67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 Univ. Hosp. Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Carroll Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): FINKSBURG
D. STREET ADDRESS (If rural, give location): 56-0

5. SEX: M
6. RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 11 27 94
9. AGE (In years, last birthday): 73
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housed in bakery & Chem. plant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Greenbrier County, W. Va. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Uriah Rose
14. MOTHER'S MAIDEN NAME: Nancy Taylor

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): yes
(If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO. 234-26-5412-A
17. INFORMANT: Mrs. Gertie G. Rose
ADDRESS: Finksburg #2 Maryland

MEDICAL CERTIFICATION

18. 33 / X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pericardial Effusion
DUE TO
(B) Intra Cerebral Hemorrhage
DUE TO
(C)
15 min

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9 Dec 67 19 to 9 Dec 67 19, that (I) (we) last saw the deceased alive on 9 Dec 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. W. Eichhorn M.D.
Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 9 Dec 67
23C. PHYSICIAN'S NAME (Type): John W. Eichhorn M.D.
23D. ADDRESS: Univ. Md Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 12/12/67
24C. NAME of CEMETERY or CREMATORY: Lake View Mem. Gardens
24D. LOCATION (City, town, or county) (State): Sykesville RD Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Lankford M.D.
25C. FUNERAL DIRECTOR: F. E. Myers Jr. Westminster, Md.
ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-512 1

BIRTH NO. Kent Co., Md. 67 11869

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 11869

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Thompson, Edward

2. DATE AND HOUR OF DEATH 10:35 P.M. Dec. 7, 67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Queen Anne's Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township) SUDLERSVILLE 67-00
D. STREET ADDRESS (If rural, give location)

5. SEX M
6. RACE W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)
8. DATE OF BIRTH 7/9/67
9. AGE (In years last birthday) If Under 1 Yr. Months 5 Days 3 If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Thompson, Edward D.
14. MOTHER'S MAIDEN NAME Thompson, Gladys

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Edward Thompson, ADDRESS Sudlersville, Maryland

MEDICAL CERTIFICATION

1B. 754.5 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH
(A) Congenital Heart Disease
DUE TO
(B) Total anomalous
DUE TO
(C) Venous Return

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonitis

19A. DATE OF OPERATION 11/14/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cong. Ht. Disease Cardiac Cath
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (~~this hospital~~) attended the deceased from Dec 3 1967 to Dec 7 1967, that (I) (we) last saw the deceased alive on Sept 7 (10:35 PM) 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Joseph H. Richman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED Dec. 7, 67
23C. PHYSICIAN'S NAME (Type) Joseph H. Richman M.D.
23D. ADDRESS Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify) Burial
24B. DATE Dec. 9
24C. NAME of CEMETERY or CREMATORY Salem Church yard
24D. LOCATION (City, town, or county) (State) Rural Centreville, Maryland

25A. DATE REC'D BY HEALTH DEPT. DEC 12 1967
25B. NAME OF REGISTRAR Robert E. Fankyna
25C. FUNERAL DIRECTOR Edgar L. Lane ADDRESS Church Hill, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

50-26-66
IW

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M-420 67 11870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11870

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MILLS, Madeline
MILLS, MADELINE

2. DATE AND HOUR OF DEATH: 12/7/67 11:55 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 Eastern Avenue, Baltimore, Maryland 21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ESSEX
53-00
D. STREET ADDRESS (If rural, give location): 316 Wye Road - 21221

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 10/31/89
9. AGE (In years last birthday): 78
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE STEVENS
14. MOTHER'S MAIDEN NAME: MARGARET

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-16-6458
17. INFORMANT RECORDS: Baltimore City Hospitals
ADDRESS 4940 Eastern Avenue, Baltimore, Md. 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) (2) CVA C (R) Leukemia — ?
DUE TO H/O recent colectomy & sigmoidectomy & colostomy
(B) DUE TO — 3 mos
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 9/26/67 & 10/23/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Sigmoidectomy, Chronic colostomy
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/26 1967 to 12/7 1967, that (I) (we) last saw ~~the deceased~~ alive on 12/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Leonard Lipp M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/7/67
23C. PHYSICIAN'S NAME (Type): LEONARD LIPPMAN
LEONARD LIPPMAN M.D.
23D. ADDRESS 4940 Eastern Avenue, Balto., Md. 21224
BALT. CITY Hospitals

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/11/67
24C. NAME of CEMETERY or CREMATORY: OAK LAWN CEM
24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: J.J. CONNELLY SONS
ADDRESS: 300 MACE

VS 150-REV. 1/1/65

5-365-1

67 11871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11871

BIRTH NO.

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Daisy Strohm

2. DATE AND HOUR OF DEATH: Dec. 9, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Belvedere House in the Pines

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 3614 Sylvan Drive # 7

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 10-29-1882
9. AGE (In years last birthday): 85
If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Utterbaugh
14. MOTHER'S MAIDEN NAME: Mary Jane Bell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-05-7593
17. INFORMANT: George T. Strohm, Sr. ADDRESS: 3614 Sylvan Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer of Stomach

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Col. Insuff.

19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Milton Schlenoff M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/9/67
23C. PHYSICIAN'S NAME (Type): MILTON SCHLENOFF, M. D. M.D.
23D. ADDRESS: 6410 Windsor Mill Rd.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-12-67
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Ellsworth Armacost ADDRESS: 4600 Liberty Hghts. Ave

VS 150-REV. 1/1/65

I-546 67 11872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11872

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): IMLER, Eugene Peter

2. DATE AND HOUR OF DEATH: 12-7-67 | 6:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Boulevard, Baltimore, Maryland 21218

27

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Pennsylvania

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): York

V-35

D. STREET ADDRESS (If rural, give location): 232 South Persing Avenue

5. SEX: Male

6. RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced

8. DATE OF BIRTH: 12-1-15

9. AGE (In years last birthday): 52

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Loysburg, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Imler

14. MOTHER'S MAIDEN NAME: Clara Bingham

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 162-12-99-47

17. INFORMANT: Hospital Records

ADDRESS: 3900 Loch Raven Blvd, Baltimore, Maryland

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 163 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Metastasis to Pericardium	3 Weeks
	DUE TO (B) Cancer of Lungs	6 Months
ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 6 December 1967 to 7 December 1967, that ~~I~~ (we) last saw the deceased alive on 7 December 1967 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) ~~did not~~ view the body after death.

23A. SIGNATURE: GARY D. PLOTNICK, M.D.

M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12-8-67

23C. PHYSICIAN'S NAME (Type): Gary D. Plotnick M.D.

23D. ADDRESS: 3900 Loch Raven Blvd. V.A. Hospital, Baltimore, Md. 21218

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 12/10/67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State): Holidaysburg Penna.

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Chas E. Fisher

25C. FUNERAL DIRECTOR: W. E. Johnson

ADDRESS: 8521 Loch Raven Blvd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

49-47-67 ED 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 0-600 67 11873 Registered No. 67 11873

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BERTHA O'HARA

2. DATE AND HOUR OF DEATH: 8 DECEMBER 1967 | 9:20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Ave., Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 1-01
D. STREET ADDRESS (If rural, give location): 845 S. Kenwood Ave. # 21224 005

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Married	2-1-23	44		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	West Virginia	U.S.A.

13. FATHER'S NAME: Grover Lamar Bennett

14. MOTHER'S MAIDEN NAME: Josie Bell Clouston

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: BCH: Records 4940 Eastern Ave. Baltimore, Md. ADDRESS # 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 171X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) CARCINOMA OF CERVIX — 5 months
DUE TO
(B) UREMIA — 1 month
DUE TO
(C) ANEMIA — ?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 28 NOVEMBER 1967 to 8 DECEMBER 1967, that (we) last saw the deceased alive on 8 DECEMBER 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.

23A. SIGNATURE: Michael R. McMilliam M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 8 DECEMBER 1967

23C. PHYSICIAN'S NAME (Type): Michael R. Mc Milliam M.D.

23D. ADDRESS: BALTIMORE CITY HOSPITALS BALTIMORE Md 4940 Eastern Ave. Baltimore, Md. # 21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/12/67	Brick Church Cem.	Huttonsvill, West Virgina

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Farkyma

25C. FUNERAL DIRECTOR: W. E. Johnson ADDRESS: 8521 Loch Raven Blvd.

VS 150-REV. 1/1/65

1

T-145

67 11874 BALTIMORE CITY HEALTH DEPARTMENT 67 11874

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SOLOMON (SOL) TUBLIN

2. DATE AND HOUR PRONOUNCED DEAD: December 8, 1967 3:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 5725 Ranny Road

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

27-15

D. STREET ADDRESS (If rural, give location): 5725 Ranny Road

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widower

8. DATE OF BIRTH: NOVEMBER 7, 1913

9. AGE (In years last birthday): 54

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10B. KIND OF BUSINESS OR INDUSTRY: Womens wear

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Morris Tublin

14. MOTHER'S MAIDEN NAME: Leah ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes

(If yes, give war or dates of service): USNAVY WWII

16. SOCIAL SECURITY NO.: 214-03-9940

17. INFORMANT: Mrs Lois Butowsky

ADDRESS: 1250 4 Cedarbrook

MEDICAL CERTIFICATION

18. E976X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Gunshot Wound of Head

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 5725 Ranny Road

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12/8/67 Unknown m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? shot self in head

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [X] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 12/9/67

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial

23B. DATE: Dec 10/67

23C. NAME OF CEMETERY or CREMATORY: Oheb Shalom

23D. LOCATION (City, town, or county) (State): Baltimore, Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

24B. NAME OF REGISTRAR: Robert E. Faulkner M.D.

24C. FUNERAL DIRECTOR: Sol Leunson Inc

ADDRESS: 6000 Reist Pl

VS 151-REV. 1/1/65

N856.4

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-632 67 11875

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11875

1. NAME OF DECEASED (Type or Print): GOLDIE SCHWARTZ

2. DATE AND HOUR OF DEATH: 12/8/67 | 2:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSP 4250 NIAG

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO 217
D. STREET ADDRESS (If rural, give location): WILLOWDALE NURSING HOME

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE F	WHITE W	WIDOW W	~~XXXXXXXXXX~~	90 ~~XXX~~		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	AT HOME	RUSSIA	U.S.A.

13. FATHER'S NAME: ? COHEN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NO

17. INFORMANT: MR. PAUL SCHWARTZ, ADDRESS: 8410 CARLSON LANE #21207

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) ASCVD
DUE TO
(B) PERIPH. VASC DIS
DUE TO
(C) WITH GANGRENE OF LOWER EXTREMS

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11/15/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: PERIPH VASC DIS. GANGRENE

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 11/10 19 67 to 12/8 19 67, that I (we) last saw the deceased alive on 12/8 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE: Edward R Cohen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/8

23C. PHYSICIAN'S NAME (Type): E. R. COHEN M.D.

23D. ADDRESS: Sinai Hosp

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12-10-67

24C. NAME of CEMETERY or CREMATORY: WORKMENS CIRCLE

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Tilley M.D.

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., ADDRESS: 6010 REISTERSTOWN RD.

VS 150-REV. 1/1/65

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. S-550 67 11876 Registered No. 67 11876

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH SIMON

2. DATE AND HOUR OF DEATH: 12/8/67 1:40 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-11
D. STREET ADDRESS (If rural, give location): HILTON VILLAGE, DOLFIELD AVENUE

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH:
9. AGE (In years last birthday): 82
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN
10B. KIND OF BUSINESS OR INDUSTRY: MENS CLOTHING
11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LOUIS SIMON
14. MOTHER'S MAIDEN NAME: LEAH ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS. AL STEIN
ADDRESS: 6612 CROSS COUNTRY BLVD. #15

MEDICAL CERTIFICATION

1B. 491 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH: 16 days

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/22/67 19 to 12/8/67 19, that (I) (we) last saw the deceased alive on 12/8/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/8/67
23C. PHYSICIAN'S NAME (Type): B. FETTNER M.D.
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12-10-67
24C. NAME of CEMETERY or CREMATORY: BALTIMORE HEBREW
24D. LOCATION (City, town, or county) (State): Reisterstown [redacted], MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: [signature]
25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC.
ADDRESS: 6010 REISTERSTOWN

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. X-100 67 11877

Registered No. 265-693 67 11877

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): TILLIE YAFFE.

2. DATE AND HOUR OF DEATH: 12/9/1967 | 12-25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTIMORE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE. 27-19

D. STREET ADDRESS (If rural, give location): 5522 RUBIN AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	MARRIED	9/13/11	56.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at Home	Baltimore, Md	USA

13. FATHER'S NAME: Isaac Herr

14. MOTHER'S MAIDEN NAME: Mary ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): N

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: D. J. Pradhan M.D. ADDRESS: Sinai Hospital of Baltimore

MEDICAL CERTIFICATION

18. 230 X 1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) RENAL FAILURE WITH ACIDOSIS

DUE TO

(B) POST-OPERATIVE SHOCK.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY: Robert E. Farley, M.D. ASST. MEDICAL EXAMINER 12/12/67

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
12/7/67 and 12/8/67	(1) Renal Poly and cholelithiasis (2) Intestinal Obstruction		

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
☐		

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that ~~I~~ (this hospital) attended the deceased from 12/6 1967 to 12/9 1967, that (I) (we) last saw the deceased alive on 12/9 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: D. J. Pradhan M.D. ☐ Attending Phys. ☐ Med. Director ☑ Staff Phys.

23B. DATE SIGNED: 12/9/1967

23C. PHYSICIAN'S NAME (Type): D. J. PRADHAN. M.D.

23D. ADDRESS: SINAI HOSPITAL OF BALTIMORE.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Dec 10/67	Beth Israel	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 12 1967	Robert E. Farley, M.D.	Sol Leunor & Bros Inc	6000 Reisterstown Rd

VS 150-REV. 1/1/65

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

Body released to Sol Leunor 12-9-67 Medical Examiner notified 12-9-67 9:11 AM (9:45 AM)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. L-130 67 11878 Registered No. 67 11878

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ADA ~~XXXXXXXXXXXX~~ W. LEVITT

2. DATE AND HOUR OF DEATH: 12/6/67 5:53 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL OF BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: BALTIMORE Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~BALTIMORE~~ RANDALLSTOWN 53.00

D. STREET ADDRESS (If rural, give location): 8620 LUCERNE ROAD

5. SEX	6. RACE	7. MARITAL STATUS (Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	CAUC	MARRIED	11-28-20	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	AT HOME	NEW YORK CITY	U.S.A.

13. FATHER'S NAME: SAM WIENER

14. MOTHER'S MAIDEN NAME: LENA COHEN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 130-12-8175

17. INFORMANT: MR. LOUIS LEVITT, RANDALLSTOWN, MD. 21133 ADDRESS: 8620 LUCERNE ROAD

MEDICAL CERTIFICATION

1B. 260 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: MYOCARDIAL INFARCTION — 6 hours

(B) DUE TO: ASCVD

(C) DIABETES MELLITUS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/6 1967 to 12/6 1967, that (I) (we) last saw the deceased alive on 12/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Abe Levy M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/6/67

23C. PHYSICIAN'S NAME (Type): ABE LEVY M.D.

23D. ADDRESS: Sinai Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	12-8-67	CHIZUK AMUNO (ARLINGTON)	BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Fahey

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS., ADDRESS: 6010 REISTERSTOWN ROAD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. K-246

67 11879

Registered No. 67 11879

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Barnet Kessler

2. DATE AND HOUR OF DEATH: December 9, 1967 5:55 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Mt Sinai Nursing Home 4613 Park Hts Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: New York B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): New York V-29

D. STREET ADDRESS (If rural, give location): 888 - 8th Avenue

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widower

8. DATE OF BIRTH: 1884

9. AGE (In years last birthday): 83

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Presser

10B. KIND OF BUSINESS OR INDUSTRY: Clothing

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Solomon Funeral Home - 420 Harvard St Brookline, Mass.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 443X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Hypertensive Arteriosclerotic

DUE TO

(C) Heart Disease — 10 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/15 1957 to 12/9 1967, that (I) (we) last saw the deceased alive on 12/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: I Zinberg M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Dec 9/67

23C. PHYSICIAN'S NAME (Type): ISRAEL ZINBERG M.D.

23D. ADDRESS: 4000 W. Northern Pkwy

24A. BURIAL CREMATION, REMOVAL (Specify): Removal

24B. DATE: Dec 9/67

24C. NAME of CEMETERY or CREMATORY: Jewish Deed Holders

24D. LOCATION (City, town, or county) (State): Everett, Mass.

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Talley M.D.

25C. FUNERAL DIRECTOR: Sol Leunson & Bros Inc

ADDRESS: 6010 West Rd

VS 150-REV. 1/1/65

BIRTH NO. G-355 67 11880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11880

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BENJAMIN F. GOODMAN

2. DATE AND HOUR OF DEATH: 12/9/67 | 11:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: SINAI HOSPITAL OF BALTIMORE

(If not in hospital or institution, give street address or location)

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: District of Columbia

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Washington V-48

D. STREET ADDRESS (If rural, give location): 329 Oglethorpe St. N.W

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 12/25/1906

9. AGE (In years last birthday): 60

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self Employed

10B. KIND OF BUSINESS OR INDUSTRY: C. P. A.

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Goodman

14. MOTHER'S MAIDEN NAME: Mollie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No.

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Bernard Dougherty & Sons

ADDRESS: Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ? PULMONARY EMBOLISM — 1 hr

DUE TO

or

(B) ? MYOCARDIAL INFARCTION — 1 day

DUE TO

(C) 2° ASHD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES, CHRONIC LIVER DISEASE

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/9 1967 to 12/9 1967, that (I) (we) last saw the deceased alive on 12/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard Katon M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/9/67

23C. PHYSICIAN'S NAME (Type): RICHARD KATON M.D.

23D. ADDRESS: SINAI HOSPITAL OF

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 12-9-67

24C. NAME of CEMETERY or CREMATORY: King David Memorial

24D. LOCATION (City, town, or county) (State): Falls Church Va.

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Farley

25C. FUNERAL DIRECTOR: Sol Levinson & Bros.

ADDRESS: 6010 Reisterstown Rd.

VS 150-REV. 1/1/65

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

Released by Medical Examiner - Thomas Smith

1

1

H-620 67 11881

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 11881

BIRTH NO.

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ward T. Gregory W. HARRIS

2. DATE AND HOUR PRONOUNCED DEAD: December 9, 1967 6:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-03

D. STREET ADDRESS (If rural, give location): 1607 Laurens Street

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: 10-23-37

9. AGE (In years last birthday): 30

If Under 1 Yr. Months Days Hours Min. / If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Harris

14. MOTHER'S MAIDEN NAME: Lillie Gregory

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): YES (If yes, give war or dates of service): Korean Conflict

16. SOCIAL SECURITY NO.:

17. INFORMANT: Lillie Hawkins ADDRESS: same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. E982X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Stabwound of Chest Involving the Heart

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): In front of 1307 N. Fulton Avenue

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12/9/67 6:00 P. m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Subj. stabbed on the street 15-02

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 12/10/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12-14-67

23C. NAME of CEMETERY or CREMATORY: Balto. Nat'l. Cem.

23D. LOCATION (City, town, or county) (State): Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

24B. NAME OF REGISTRAR: Robert E. Stalkup

24C. FUNERAL DIRECTOR: Kelson Funeral Home ADDRESS: 1348 Calhoun St.

VS 151-REV. 1/1/65

N 861.2

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-520

BIRTH NO.

M.E. CASE NO.

67 11882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11882

1. NAME OF DECEASED (Type or Print): ROBERT JONES

2. DATE AND HOUR OF DEATH: 12/10/67 | 5:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

9-08

D. STREET ADDRESS (If rural, give location): 644 BARTLETT AVENUE

5. SEX: MALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 2-11-18

9. AGE (In years last birthday): 49

If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM JONES

14. MOTHER'S MAIDEN NAME: BERTHA ANDERSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes

(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 215127717

17. INFORMANT: Audrey Jones

ADDRESS: 644 Bartlett Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) METASTATIC PROSTATIC CA — INTERVAL BETWEEN ONSET AND DEATH: ? 4 mo.

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. UTI and SEPSIS; ? CAS TB

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/26 19 67 to 12/10 19 67, that (I) (we) last saw the deceased alive on 12/10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harry K Genant M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12/10/67

23C. PHYSICIAN'S NAME (Type): HARRY K. GENANT M.D.

23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-14-67

24C. NAME of CEMETERY or CREMATORY: Balto. Nat'l. Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Kelson Funeral Home

ADDRESS: 1348 Calhoun St

VS 150-REV. 1/1/65

1

M-341 67 11883

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11883

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Willa Mae Smith Middlebrook

2. DATE AND HOUR PRONOUNCED DEAD: December 7, 1967 | 5:30 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

28-41

D. STREET ADDRESS (If rural, give location): 3711 Mohawk Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Colored	married	3-30-28	39				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		S.C.	U.S.A.

13. FATHER'S NAME: Wm. Rock

14. MOTHER'S MAIDEN NAME: Louise

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

16. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Savin Funeral Home

ADDRESS: Phila., Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E981X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot wound of the chest

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1st floor 3711 Mohawk Ave. 28-41

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12 7 67 4:30 p.m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Subject shot supposedly accidentally

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [X]

ACTUAL SIGNATURE: Edward F. Wilson M.D.

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: December 8, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12-14-67

23C. NAME of CEMETERY or CREMATORY: Merion Valley Cem.

23D. LOCATION (City, town, or county) (State): Kennard, Pa.

24A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Kelson Funeral Home

ADDRESS: 1348 Calhoun St

VS 151-REV. 1/1/65

N835.4

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. W-425

M.E. CASE NO. 67 11884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11884

1. NAME OF DECEASED (Type or Print): Ernest Wilson

2. DATE AND HOUR OF DEATH: 12-7-67 | 12:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital Inc. 1514 Division Street Baltimore, Maryland 21217

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4103 Fairfax Road

15-09

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 4-10-09
9. AGE (In years last birthday): 58
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Hodges Wilson
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 213-07-1904
17. INFORMANT: Mrs. Eva Wilson- wife
ADDRESS: Mo4-1049 Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 331X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 2, 1967 to December 7, 1967, that (I) (we) last saw the deceased alive on December 7, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Gregorio S. Tengco M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-7-67
23C. PHYSICIAN'S NAME (Type): GREGORIO S. TENGCO M.D.
23D. ADDRESS: 1514 Division St.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-11-67
24C. NAME of CEMETERY or CREMATORY: Mt. Nebo Cem.
24D. LOCATION (City, town, or county) (State): Crew, Va.

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Tanner
25C. FUNERAL DIRECTOR: Kelson Funeral Home
ADDRESS: 1348 N. Calhoun St

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-200

BIRTH NO. 67 11885

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11885

1. NAME OF DECEASED (Type or Print): Gilbert D. Hayes

2. DATE AND HOUR OF DEATH: 12-10-67 | 7:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc.

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 13-04

D. STREET ADDRESS (If rural, give location): 1616 Clifton Avenue

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 6-22-1907

9. AGE (In years last birthday): 60

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Hayes

14. MOTHER'S MAIDEN NAME: Minnie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Annie Hayes - Wife

ADDRESS: SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 491 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 9, 19 67 to December 10, 19 67, that (I) (we) last saw the deceased alive on December 10, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X

23B. DATE SIGNED: 12-11-67

23C. PHYSICIAN'S NAME (Type): GREGORIO S. TENGCO M.D.

23D. ADDRESS: 1514 Division Street Balto., Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-13-67

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Kelson Funeral Home

ADDRESS: 1348 Calhoun St.

VS 150-REV. 1/1/65

B-6210

BIRTH NO. 67 11886

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11886

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ANGELA BOURG

2. DATE AND HOUR OF DEATH: DEC. 8, 1967 — 7:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 9-09
D. STREET ADDRESS (If rural, give location): 1400 VALLEY STREET

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 5-24-81
9. AGE (In years last birthday): 86
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: EDWIN WALKER
14. MOTHER'S MAIDEN NAME: ANNA KURTZ

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Onedah Smith — ADDRESS: 6253 Robin Hill Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.0 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema — Minutes

DUE TO

(B) Chronic CHF — yrs

DUE TO

(C) A. S. H. D. — yrs

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gangrene of (Rt) Foot — mos.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DEC. 6 1967 to DEC. 8 1967, that (I) (we) last saw the deceased alive on DEC. 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Samuel A. Torres M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12-8-67
23C. PHYSICIAN'S NAME (Type): SAMUEL A. TORRES M.D.
23D. ADDRESS: MERCY HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/11/67
24C. NAME of CEMETERY or CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Fashyna
25C. FUNERAL DIRECTOR: Philip Herwig Sons
ADDRESS: 2024 Orleans St

VS 150-REV. 1/1/65

P-07

B-500d

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11887 Registered No. 67 11887

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Clara Boone

2. DATE AND HOUR OF DEATH: 12·10·67 | 10:50 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Srs. of The Poor 90 1200 Valley St. Balt. Md. 21202

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1200 Valley St.

10-01

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
8. DATE OF BIRTH: 1-30-1878
9. AGE (In years last birthday): 89
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleswoman
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): ?
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Glady
14. MOTHER'S MAIDEN NAME: Laura Edell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 213-54-2589
17. INFORMANT: Little Srs. of The Poor
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) A.S.C.V.D – bulmo
DUE TO
(B) Navy edema, Generalized arteriosc
DUE TO
(C) vosis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ____ 1966 to Dec 10 1967, that (I) (we) last saw the deceased alive on Dec 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stanley Ankudas M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12.11.67
23C. PHYSICIAN'S NAME (Type): Stanley Ankudas M.D.
23D. ADDRESS: 1101 Maiden Choice Lane Balt. Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/13/67
24C. NAME of CEMETERY or CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Baltimore

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Fahey
25C. FUNERAL DIRECTOR: Philip Herwig Sons
ADDRESS: 2024 Orleans St

VS 150-REV. 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452

67 11888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11888

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANNA THERESA WILLINGER

2. DATE AND HOUR OF DEATH: 12-10-67 | 5:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 LITTLE SISTERS OF THE POOR 1200 VALLEY STREET BALTIMORE, MD. 21202

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: A.A. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): GLEN BURNIE 52-00

D. STREET ADDRESS (If rural, give location): BOX 179 ROUTE 2

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 12-30-89

9. AGE (In years last birthday): 78

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): AUSTRIA HUNGRY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE DORES

14. MOTHER'S MAIDEN NAME: SCHWABEK (ANNA)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 212-05-3090

17. INFORMANT: LITTLE SISTERS OF THE POOR

ADDRESS: 1200 VALLEY STREET BALTIMORE, MD. 21202

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — 331 X

1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) C.V.A.

DUE TO

(B) Hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ____ 19 65 to Dec 10 19 67, that (I) (we) last saw the deceased alive on Dec. 11, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stanley Ankudas M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-11-67

23C. PHYSICIAN'S NAME (Type): STANLEY ANKUDAS M.D.

23D. ADDRESS: 1101 MAIDEN CHOICE LANE - BALTIMORE, MD.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/12/67

24C. NAME of CEMETERY or CREMATORY: Glen Haven

24D. LOCATION (City, town, or county) (State): Baltimore

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Philip Herurg Sons

ADDRESS: 2024 Orleans St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
E-152

67 11889 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11889

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARY LEE EVANS

2. DATE AND HOUR PRONOUNCED DEAD: December 10, 1967 7:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): University Hospital (DOA)

38/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: X
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 701 W. Mulberry St Apt # 401

4-02

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: July 30-1952
9. AGE (In years last birthday): 15
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT
10B. KIND OF BUSINESS OR INDUSTRY: PUBLIC SCHOOL
11. BIRTHPLACE (State or foreign country): CHESTERFIELD Co. S.C.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: THOMAS EVANS
14. MOTHER'S MAIDEN NAME: MAGGIE McQUEEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: MAGGIE EVANS
ADDRESS: 701 W Mulberry St

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 651.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia Following Abortion

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: X
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 12/10/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12/14/67
23C. NAME of CEMETERY or CREMATORY: Mt Auburn
23D. LOCATION (City, town, or county) (State): Balto Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
24B. NAME OF REGISTRAR: Robert E. Tankersley
24C. FUNERAL DIRECTOR: Marshall P. Hayes
ADDRESS: 638 N. Gilmor St

VS 151-REV. 1/1/65

B-164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11890 Registered No. 67 11890

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BEVERLY, BROKENBURRGH

2. DATE AND HOUR OF DEATH: 12-8-1967 | 8-05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran hospital 730, Ashburton St Baltimore MD

46

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

1607

D. STREET ADDRESS (If rural, give location): 2702, Ellicott DR

5. SEX: Male

6. RACE: Coloured

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 5-5-1905

9. AGE (In years last birthday): 62

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY: Water Front

11. BIRTHPLACE (State or foreign country): Tappahach, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. Mose Beverly

14. MOTHER'S MAIDEN NAME: Annie Owens

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-09-7735

17. INFORMANT: Goldie Beverly

ADDRESS: 2702 Ellicott Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

493X

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 12-7-1967 to 12-8-1967, that (I) (we) last saw the deceased alive on 12-8-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: B.A. Desai M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: Dec. 8th 1967

23C. PHYSICIAN'S NAME (Type): B.A. Desai M.D.

23D. ADDRESS: Lutheran hospital. Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/11/67

24C. NAME of CEMETERY or CREMATORY: Carver Memorial Park

24D. LOCATION (City, town, or county) (State): Laurel Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Falkner

25C. FUNERAL DIRECTOR: Herbert E. Nutter

ADDRESS: 3035 N. Nord. Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
J-635

67 11891 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11891

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LYNDE JORDON

2. DATE AND HOUR PRONOUNCED DEAD: December 1, 1967 7:10 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1207 Beaumont Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-09

D. STREET ADDRESS (If rural, give location): 1207 Beaumont Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Married	Nov 4, 1945	22				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Brakeman	Penna Railroad	Baltimore, Maryland	U.S.A

13. FATHER'S NAME: Linwood H. Jordon

14. MOTHER'S MAIDEN NAME: Hermia Monroe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-44-4075

17. INFORMANT: Mr. Linwood H. Jordon ADDRESS: 3721 Nortonia Rd

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 996 X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Contact gunshot wound of mouth

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1207 Beaumont Avenue

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12-1-67 (about) 6:50 A.m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Shot self

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [X] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE Charles S. Springate M.D.

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED December 1, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county)	(State)
Burial	12/5/67	Arbutus Memorial Park	Arbutus	Balto Co. Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 12 1967	Robert E. Faulkner	Herbert E. Nutter	3035 W. North A ve

VS 151-REV. 1/1/65

N 573.4

P11

F 6401

67 11892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11892

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Grady Edward Ferrell Jr.

2. DATE AND HOUR OF DEATH: 12-10-67 6 30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): USPH Service Hosp Wyman Park Drive Baltimore Md

28

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: FLA.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Tampa

V-08

D. STREET ADDRESS (If rural, give location): 4415 Brooklyn Ter.

5. SEX: M

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: 12-26-34

9. AGE (In years last birthday): 32

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inspector.

10B. KIND OF BUSINESS OR INDUSTRY: Government

11. BIRTHPLACE (State or foreign country): Ga.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Grady E. Ferrell Sr.

14. MOTHER'S MAIDEN NAME: Gussie White

15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown): YES

(If yes, give war or dates of service): 1952-1954

16. SOCIAL SECURITY NO.: 267-38-8837

17. INFORMANT: Hospital Record

ADDRESS:

MEDICAL CERTIFICATION

18. 204.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Right Upper Lobe Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO

(B) Lymphoblastic Leukemia — months

DUE TO

~~(C)~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from NOV. 14 19 67 to DEC. 10 19 67, that (I) (we) last saw the deceased alive on DEC 10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: William L Wilkie M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12-10-67

23C. PHYSICIAN'S NAME (Type): William L. Wilkie M.D.

23D. ADDRESS: SAME AS #3

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-14-67

24C. NAME of CEMETERY or CREMATORY: Shady Grove

24D. LOCATION (City, town, or county) (State): Tampa, Fla.

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Tankey M.D.

25C. FUNERAL DIRECTOR: Stone's Funeral Home, 2401 E. Columbus Dr. Tampa, Fla.

ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J 52

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11893 Registered No. 67 11893

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ESTELLA JOHNSON

2. DATE AND HOUR OF DEATH: DECEMBER 9, 1967 7:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 17-02

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 1103 BORN COURT

5. SEX: Female

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 8-29-1907

9. AGE (In years last birthday): 60

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Johnson

14. MOTHER'S MAIDEN NAME: Lulor ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: FRANKLIN SQUARE HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

1B. 450.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Shock 2° to sepsis

DUE TO dehydration & malnutrition

(B) Chronic renal failure

DUE TO

(C) Generalized arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from DECEMBER 5 1967 to DEC. 9 1967, that (I) (we) last saw the deceased alive on DECEMBER 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ruben V. Luna M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-9-67

23C. PHYSICIAN'S NAME (Type): RUBEN V. LUNA M.D.

23D. ADDRESS: FRANKLIN SQUARE HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/9/1967

24C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cem.

24D. LOCATION (City, town, or county) (State): Cedar Hill Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Fahey

25C. FUNERAL DIRECTOR: Williams Funeral Home

ADDRESS: 3199 Belrose Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T 610

1

BIRTH NO. 67 11894

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11894

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM M. THORPE

2. DATE AND HOUR PRONOUNCED DEAD: December 10, 1967 | 3:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1830 St. Paul St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-05

D. STREET ADDRESS (If rural, give location): 1830 St. Paul St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	MARRIED	FEB. 16 1885	82				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMING		VIRGINIA	USA

13. FATHER'S NAME: WILLIAM THORPE

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: EFFIE THORPE

ADDRESS: 2505 WENDOVER RD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Werner U. Spitz, M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 12/10/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	12-13-67	PARKWOOD CEMETERY	BALTO, MD.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 12 1967	Robert E. Farley M.D.	JOHN M WEBER & SONS INC	401 S. CHESTER ST

VS 151-REV. 1/1/65

L 263 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11895 Registered No. 67 11895

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Agnes A. Lechert

2. DATE AND HOUR OF DEATH: 12-7-67 5 25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 35 Church Home + Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 2-02

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 216 S. Ann St

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	Widowed	8-23-03	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Ignatius Kotecki

14. MOTHER'S MAIDEN NAME: Anna Wieprecht

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 1-12-34-9367

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 18 mos

DUE TO

(B) Arteriosclerotic Cardio-vascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-27 1967 to 12-7 1967, that (I) (we) last saw the deceased alive on 12-7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Rodelio M. Lim M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-7-67

23C. PHYSICIAN'S NAME (Type): Rodelio M. Lim M.D.

23D. ADDRESS: CHH

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/12/67

24C. NAME of CEMETERY or CREMATORY: HOLY ROSARY CEM

24D. LOCATION (City, town, or county) (State): BALTO MD

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: JOHN M. WEBER & SONS INC. ADDRESS: 401 S CHESTER

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

46-83-56 1B

H.620

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11896 Registered No. 67 11896

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HARRIS, Ethel

2. DATE AND HOUR OF DEATH: 12-10-67 11:15 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 31 Baltimore Maryland 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: 26-09
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 905 S Baylis St

5. SEX: F
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 11-25-02
9. AGE (In years last birthday): 65
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): S. C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Franklin
14. MOTHER'S MAIDEN NAME: Franklin, Annie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS-BCH-4940 EASTERN AVENUE,
ADDRESS: BALTIMORE, MD. 21224

MEDICAL CERTIFICATION

18. 3322 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) G. I. Hemorrhage +
DUE TO Peptic ulcer -
(B) Cerebral infarction
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12-3-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Bleeding Peptic Ulcer
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-2- 1967 to 12-10 1967, that (I) (we) last saw the deceased alive on 12-10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Z. A. McDonald M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-10-67
23C. PHYSICIAN'S NAME (Type): Z. A. McDonald M.D.
23D. ADDRESS: 4940 EASTERN AVENUE, BALTIMORE, MD Baltimore City Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/15/67
24C. NAME of CEMETERY or CREMATORY: York Mem Park
24D. LOCATION (City, town, or county) (State): Charlotte N. C

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Charles A Rice
ADDRESS: 661 W. Barre St

VS 150-REV. 1/1/65

5.300

67 11897

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67-14541

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11897

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALLEN SCOTT (Alan Duane Scott)

2. DATE AND HOUR PRONOUNCED DEAD: December 11, 1967 | 10:53 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital

43/99

D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2371 Seamon Ave.

25-32

5. SEX: Male

6. RACE: Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 7/23/67

9. AGE (In years last birthday): If Under 1 Yr. Months: 5 Days: Hours: If Under 24 Hrs. Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alan Duane Scott

14. MOTHER'S MAIDEN NAME: Mary Meadows

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Alan D. Scott 2371 Seaman Ave

ADDRESS:

MEDICAL CERTIFICATION

1B. 795.2

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Sudden Death in Infancy

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 11, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/13/67

23C. NAME of CEMETERY or CREMATORY: Mt. Calvery

23D. LOCATION (City, town, or county) (State): Brooklyn, Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Charles A. Rice

ADDRESS: 661 W. Barre St.

VS 151-REV. 1/1/65

50-73-19 IW

W420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11898 Registered No. 67 11898

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANNIE WALLACE
Annie Wallace

2. DATE AND HOUR OF DEATH: December 11, 1967 | 1045 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

CERTIFICATE AMENDED 12-21-67

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS
4940 Eastern Avenue
Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 20-07
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 509 Mt. Holly Street

5. SEX: FEMALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 8/30/85
9. AGE (In years last birthday): 82
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNK
14. MOTHER'S MAIDEN NAME: UNK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 217-54-1278T
17. INFORMANT RECORDS: Baltimore City Hospital ADDRESS 4940 Eastern Avenue, Balto., Md. 21224

CAUSE OF DEATH

1B. 338 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 14 hrs.

DUE TO

(B) Atherosclerosis

DUE TO

(C) Cardiac arrest

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/10 19 67 to 12/11 1967, that (I) (we) last saw the deceased alive on 12/11/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Joel Thurm M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/11/67
23C. PHYSICIAN'S NAME (Type): JOEL THURM
JOEL THURM M.D.
23D. ADDRESS: BCH 4940 Eastern Avenue Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/14/67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Tankey M.D.
25C. FUNERAL DIRECTOR: Charles A. Rice ADDRESS: 661 W. Barre St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Letter from Balto. City Hospitals
12-21-67 M.H.

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-415 67 11899

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11899

1. NAME OF DECEASED (Type or Print) DR. SAMUEL LEON SLOVIN

2. DATE AND HOUR OF DEATH Dec. 9 1967 | 6 20 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2601 Liberty Hgts

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO Md 15-05

D. STREET ADDRESS (If rural, give location) 2601 Liberty Hgts AVE

5. SEX Male

6. RACE Caucas

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married

8. DATE OF BIRTH April 12 1893

9. AGE (In years last birthday) 74

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DDS

10B. KIND OF BUSINESS OR INDUSTRY Dentist

11. BIRTHPLACE (State or foreign country) ~~Pola~~ Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Loeb Slovin

14. MOTHER'S MAIDEN NAME Kassen

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT DAUGHTER Rose Slovin - Same ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO Carcinoma of the pancreas with metastases — INTERVAL BETWEEN ONSET AND DEATH: 6 mos?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none

19A. DATE OF OPERATION Nov 7, 1967

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of pancreas

20A. AUTOPSY? (Yes or No) NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 27 1967 to Dec 9 1967, that (I) (we) last saw the deceased alive on Dec 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE H. Gerald Oster M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED 12-9-67

23C. PHYSICIAN'S NAME (Type) H. GERALD OSTER M.D.

23D. ADDRESS 6821 Reisterstown Rd

24A. BURIAL CREMATION, REMOVAL (Specify) Cremation

24B. DATE 12-12-67.

24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery

24D. LOCATION (City, town, or county) Baltimore, Md. (State)

25A. DATE REC'D BY HEALTH DEPT. DEC 12 1967

25B. NAME OF REGISTRAR Robert E. Farley M.D.

25C. FUNERAL DIRECTOR Elsworth Armacost

ADDRESS 4600 Liberty Hgts

VS 150-REV. 1/1/65

T-6501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11900 Registered No. 67 11900

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GRANT THORN

2. DATE AND HOUR OF DEATH: December 9, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1101 St. Paul St. Apt. #906

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 1101

D. STREET ADDRESS (If rural, give location): 1101 St. Paul Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Dec. 17, 1896

9. AGE (In years last birthday): 70

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Executive

10B. KIND OF BUSINESS OR INDUSTRY: Petroleum

11. BIRTHPLACE (State or foreign country): California

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Owen Thorn

14. MOTHER'S MAIDEN NAME: Hilda Ryder

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): WW 1

16. SOCIAL SECURITY NO.: 216-07-6163

17. INFORMANT: Mrs. Genevieve Thorn ADDRESS: 1101 St. Paul St.

MEDICAL CERTIFICATION

18. 420.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary artery disease — 3 mos

DUE TO: Congestive heart failure

(B) Generalized arteriosclerotic cardiovascular — 10 years

DUE TO:

(C) General debilitation — 3 mos.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from — 1956 to Dec 9 1967, that (I) (~~we~~) last saw the deceased alive on Dec 7 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Harry B. Scott M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-11-67

23C. PHYSICIAN'S NAME (Type): Dr. H. B. Scott M.D.

23D. ADDRESS: Medical Arts Blg.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-13-67

24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Foxley M.D.

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Inc. ADDRESS: 1217 St. Paul St.

VS 150-REV. 1/1/66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-25 J

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11901 Registered No. 67 11901

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Julius Ashman

2. DATE AND HOUR OF DEATH: 12-10-67 | 11:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: —
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-34
D. STREET ADDRESS (If rural, give location): 5613 Lindan Lane

5. SEX: Male
6. RACE: Caucasian
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 3-30-1894
9. AGE (In years last birthday): 73
If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate Agent
10B. KIND OF BUSINESS OR INDUSTRY: Real Estate
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Bernard Ashman
14. MOTHER'S MAIDEN NAME: Sophia Blake

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): World War I - Marines
16. SOCIAL SECURITY NO.:
17. INFORMANT: Gertrude Ashman Sagle
ADDRESS: Boppa - same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

420.1

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 8 days
DUE TO
(B) Coronary Insufficiency
DUE TO
(C) Hypertension

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes —
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-2- 1967 to 12-10 1967, that (I) (we) last saw the deceased alive on 12-10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sam LeBauer M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12-10-67
23C. PHYSICIAN'S NAME (Type): Sam LeBauer M.D.
23D. ADDRESS: Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-14-67
24C. NAME of CEMETERY or CREMATORY: Mayfield Memorial
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Wm Cook-Brooks Towson, Towson Md
ADDRESS:

VS 150-REV. 1/1/65

C-160

BIRTH NO. 67 11902

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11902

1. NAME OF DECEASED (Type or Print): Thomas Cooper

2. DATE AND HOUR OF DEATH: 12-6-67 | 11:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: Provident Hospital Inc.

(If not in hospital or institution, give street address or location): 1514 Division Street, Baltimore, Maryland 21217

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

13-03

D. STREET ADDRESS (If rural, give location): 2305 Madison Ave.

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 7-21-1895

9. AGE (In years last birthday): 72

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenters Helper

10B. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Cooper

14. MOTHER'S MAIDEN NAME: Martha Hughes

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-01-0069

17. INFORMANT: Mrs. Ruth A. Cooper- wife

ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 5, 19 67 to December 6, 19 67, that (I) (we) last saw the deceased alive on December 6, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Gregorio S. Tengco M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12-7- 67

23C. PHYSICIAN'S NAME (Type): GREGORIO S. TENGCO M.D.

23D. ADDRESS: 1514 Division Street

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/10/67

24C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Park

24D. LOCATION (City, town, or county) (State): Baltimore Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Holland Funeral Home

ADDRESS: 1631 Druid Hill Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-600 67 11903

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11903

1. NAME OF DECEASED (Type or Print) ~~NICOLA OR NICKALOS OR NICKOLAS GIRO~~ Nicholas Giro

2. DATE AND HOUR OF DEATH 9 DEC '67 1:05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

37 ~~211 Gough St~~ MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY BALTO.

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 3-02

D. STREET ADDRESS (If rural, give location) 121I GOUGH ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M.	W.	MARRIED.	MAY 9th. 1889	78yr		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABOR WATER DEPT.	RETIRED	ITALY	ITALY

13. FATHER'S NAME ROSARIO GIRO

14. MOTHER'S MAIDEN NAME MICHALENA ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO		218-07-8556	MR. CARMELO GIRO	338½ TOWNSEN RD. #21

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) ACUTE MYOCARDIAL INFARCT. — Hours

DUE TO

(B) ASHD

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9 DEC 1967 to 9 DEC 1967, that (I) (we) last saw the deceased alive on 9 DEC 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE W. A. Dean Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED 9 DEC. '67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	12/13/67	HOLY REDEEMER	BALTO. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 12 1967	Robert E. Farber, M.D.	Frank Della Rocca	322 S HIGH ST.

VS 150-REV. 1/1/65

1

U-526 67 11904

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11904

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JULIA UNGAR

2. DATE AND HOUR PRONOUNCED DEAD: December 11, 1967 | 9:10 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): University Hospital D.O.A.

38/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 37 Parkin St.

18-03

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
XX Female	White	Married	10/16/1912	55				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	at Home	Baltimore Md.	U. S. A.

13. FATHER'S NAME: Adam Sliakis

14. MOTHER'S MAIDEN NAME: Anna ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): —

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mr Joseph Ungar — ADDRESS: above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

4221

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Edward F Wilson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 11, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/13/67	Loudon Park Cem.	3801 Frederick Ave Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 12 1967	Robert E. Farley M.D.	John J. Cowan & Son Inc.	901 St Dolings 23 Md.

VS 151-REV. 1/1/65

C-425

BIRTH NO. 67 11905

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11905

1. NAME OF DECEASED (Type or Print): Cullison, Norvell Allen

2. DATE AND HOUR OF DEATH: 12-8-67 | 01.20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 Franklin Square Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-01
D. STREET ADDRESS (If rural, give location): 5919 Cedonia Ave

5. SEX: Male
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 7-15-08
9. AGE (In years last birthday): 59
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): chaueppeur
10B. KIND OF BUSINESS OR INDUSTRY: Davidson Transfer Co.
11. BIRTHPLACE (State or foreign country): Baltimore MD
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Denton Cullison
14. MOTHER'S MAIDEN NAME: Bertha Boode

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-09-0989
17. INFORMANT: Sang Bock Lee — ADDRESS: Franklin Square Hosp

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) CALCIFIC AORTIC STENOSIS & CARDIAC HYPERTROPHY
~~DUE TO~~
(B) DUE TO PERFORATED GASTRIC ULCER
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12-2-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: perforated ulcer
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-2, 1967 to 12-8 1967, that (I) (we) last saw the deceased alive on 1.20 AM. 12-2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sang Bock Lee — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12-8-67
23C. PHYSICIAN'S NAME (Type): Sang Bock Lee M.D.
23D. ADDRESS: Franklin Square Hosp

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-11-67
24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: John C. Miller Inc. — ADDRESS: 6415 Belair Rd. — 21206

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

C-615 67 11906 BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11906

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALBERT G. CARBONEAU

2. DATE AND HOUR PRONOUNCED DEAD: December 6, 1967 6:07 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): St. Agnes Hospital (DOA)

40/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21228 27-14
D. STREET ADDRESS (If rural, give location): 126 OAKDALE AVE. ~~5630 Ready Avenue~~

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	MARRIED	Aug. 12, 1924	43				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SERVICE DIRECTOR	AUTO.	MASS. (Medford)	U.S

13. FATHER'S NAME: Leon Joseph CARBONNEAU

14. MOTHER'S MAIDEN NAME: VERA BROWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Y (If yes, give war or dates of service): W.W.II

16. SOCIAL SECURITY NO.: 022-16-6602

17. INFORMANT: KATHARINE C. HARRINGTON CARBONNEAU ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 420.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

DATE SIGNED: December 7, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county)	(State)
BURIAL	12/11/67	BALTO. NATIONAL CEM.	BALTO.	Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 12 1967	Robert E. Farley M.D.	E. S. MacNabb	301 Frederick Rd

VS 151-REV. 1/1/65

21228

P-362

BIRTH NO. 67 11907

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11907

1. NAME OF DECEASED (Type or Print): PATTERSON, SAMUEL ELI

2. DATE AND HOUR OF DEATH: Dec. 11 1967 | 8 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: 21061 Anne Arundel Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): GLEN BURNIE 52-00
D. STREET ADDRESS (If rural, give location): 1227 GILFORD RD., GLENBURNIE

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 3/13/97
9. AGE (In years last birthday): 70
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mech. RETIRED
10B. KIND OF BUSINESS OR INDUSTRY: George's Transfer + Rigging
11. BIRTHPLACE (State or foreign country): MD. (Hampstead)
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ~~DEC.~~ William E. Patterson
14. MOTHER'S MAIDEN NAME: Sara E. C. Cole ~~DEC.~~ ELIZABETH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W.W. I
16. SOCIAL SECURITY NO.: 212-07-7566
17. INFORMANT: Mrs. Anna M. Patterson (wife)
ADDRESS: Same As #4

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARDIO-PULMONARY FAILURE - ARREST — INTERVAL BETWEEN ONSET AND DEATH: SECS.

DUE TO

(B) CEREBRO-VASCULAR ACCIDENT — 4 DAYS

DUE TO

(C) GENERALIZED ATHEROSCLEROSIS — 4 YRS.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 7 DEC. 1967 to 11 DEC. 1967, that (I) (we) last saw the deceased alive on DEC. 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard E. Pittman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: Dec. 11, 1967
23C. PHYSICIAN'S NAME (Type): RICHARD E. PITTMAN M.D.
23D. ADDRESS: UNIVERSITY HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 14/67
24C. NAME of CEMETERY or CREMATORY: Balto. Nat'l. Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: R. Singleton
ADDRESS: Singleton Funeral Home Glen Burnie, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

R-563

BIRTH NO. 67 11908

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11908

1. NAME OF DECEASED (Type or Print): EARL E. REINHART

2. DATE AND HOUR OF DEATH: DECEMBER 9, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 SOUTH BALTIMORE GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: ANNE ARUNDEL Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): LINTHICUM 52-00
D. STREET ADDRESS (If rural, give location): 906 LYNVUE AVENUE

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: JULY 11, 1907
9. AGE (In years last birthday): 60
If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN
10B. KIND OF BUSINESS OR INDUSTRY: FINN INDUSTRIES
11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS G. REINHART
14. MOTHER'S MAIDEN NAME: MARGARET (unknown)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES
(If yes, give war or dates of service): W.W. II
16. SOCIAL SECURITY NO.: 215 05 9548
17. INFORMANT: MRS. GLORIA A. REINHART (wife) ADDRESS: SAME AS #4

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease — at least 2 yrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-27 19 65 to 11-9 19 67, that (I) (we) last saw the deceased alive on 11-9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: George C. Roveti M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12-11-67
23C. PHYSICIAN'S NAME (Type): George C. Roveti M.D.
23D. ADDRESS: 100 N. Broadway, Balto., Md., 21231

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: DEC. 13/67
24C. NAME of CEMETERY or CREMATORY: LOUDON PARK CEMETERY
24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Lankey M.D.
25C. FUNERAL DIRECTOR: Robert Pluce
ADDRESS: SINGLETON FUNERAL HOME GLEN BURNIE, MARYLAND

VS 150-REV. 1/1/65

DR. ROVETTI IS SIGNING (as substitute) FOR DR. KRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-422

BIRTH NO. 67 11909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11909

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): VILKAUCKAS, MARY GERTRUDE

2. DATE AND HOUR OF DEATH: DECEMBER 9, 1967 | 8:40A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL, CATON & WILKENS AVES., BALTIMORE, MD. 21229

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: MARYLAND 21223
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2624 COLE ST.

20-05

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 07-08-00
9. AGE (In years last birthday): 67
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: PETER Clopein DECEASED
14. MOTHER'S MAIDEN NAME: MARY GORDON DECEASED

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218 12 2518
17. INFORMANT: CATON & WILKENS AVES. ST. AGNES HOSPITAL RECORDS
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

203X

(A) Multiple Myeloma

ANTECEDENT CAUSES

DUE TO

(B)

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 9 19 67 to DECEMBER 9 19 67, that (X) (we) last saw the deceased alive on DECEMBER 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/9/67

23C. PHYSICIAN'S NAME (Type): DR. GABRIELA BRAUN M.D.
23D. ADDRESS: ST. AGNES HOSPITAL, CATON & WILKENS AVES. BALTIMORE, MD. 21229

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-12-67
24C. NAME of CEMETERY or CREMATORY: Meadowridge Cemetery
24D. LOCATION (City, town, or county) (State): Howard County, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Farberma
25C. FUNERAL DIRECTOR: Howard H. Hubbard, 4107 Wilkens Ave. 21229
ADDRESS

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11910 Registered No. 67 11910

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GLENN M. BOUCHARD 3D.

2. DATE AND HOUR OF DEATH: 12/8/67 5:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 U N MD. HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD B. COUNTY: CARROLL Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): SYKESVILLE MD. 56-00
D. STREET ADDRESS (If rural, give location): 8 1st AVE.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): DIV.
8. DATE OF BIRTH: 5/3/05
9. AGE (In years last birthday): 62
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): NEBRASKA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LOUIS R. BOUCHARD
14. MOTHER'S MAIDEN NAME: ROXIE EVERTS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNKNOWN (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 219-10-0308
17. INFORMANT: Woods Chapel, Seward, Nebraska — ADDRESS

MEDICAL CERTIFICATION

18. I. 01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CARCINOMA OF LUNG — 3 1/2 yrs.
DUE TO
(B) CARCINOMA OF BLADDER
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 3/25/64
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: TRANSITIONAL CELL CA BLADDER
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/20 19 67 to 12/8/67 19, that (I) (we) last saw the deceased alive on 12/7/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William Bloom M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/8/67
23C. PHYSICIAN'S NAME (Type): WILLIAM BLOOM M.D.
23D. ADDRESS: 2402 PICKERING DR.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-12-67
24C. NAME of CEMETERY or CREMATORY: Tomora Cemetery
24D. LOCATION (City, town, or county) (State): Tomora, Nebraska

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Farkyma
25C. FUNERAL DIRECTOR: Howard H. Hubbard, 4107 Wilkens Ave. 21229 — ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-356 67 11911

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11911

1. NAME OF DECEASED (Type or Print) Widmeyer, Walter Voltz

2. DATE AND HOUR OF DEATH 12-9-67 9:50 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00

D. STREET ADDRESS (If rural, give location) 181 Oaklee Village

5. SEX Male

6. RACE White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married

8. DATE OF BIRTH 12-24-84

9. AGE (In years last birthday) 82

If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lawrence Widmeyer

14. MOTHER'S MAIDEN NAME Leila Lowe

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-10-4138

17. INFORMANT Chart record ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 260X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) generalized arteriosclerosis

DUE TO

(B) Diabetes mellitus

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-28 1967 to 12-9 1967, that (I) (we) last saw the deceased alive on 12-9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED 12-9/67

23C. PHYSICIAN'S NAME (Type) J. Lee M.D.

23D. ADDRESS FRANKLIN SQUARE HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE

24C. NAME of CEMETERY or CREMATORY Meadowridge Mem, Park Cem

24D. LOCATION (City, town, or county) (State) Howard County, Maryland

25A. DATE REC'D BY HEALTH DEPT. DEC 12 1967

25B. NAME OF REGISTRAR Robert E. Tankey M.D.

25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229

ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-630

BIRTH NO. 67 11912

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11912

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Adelaide I Parrott

2. DATE AND HOUR OF DEATH: 12/11/67 | 8 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Gould Convalesarium

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-38
D. STREET ADDRESS (If rural, give location): 6103 Edlynne Rd. #12

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Dec. 16, 1893
9. AGE (In years last birthday): 73
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John A Lanahan
14. MOTHER'S MAIDEN NAME: Eva Senft

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr John F Parrott
ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis — 1 day
DUE TO
(B) Arterio Sclerotic Cardio Vascular Disease — Unknown
DUE TO
(C) Cerebral Vascular Sclerosis with Thrombosis — Unknown

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from January 12 1967 to Dec. 11 1967, that (I) (~~we~~) last saw the deceased alive on Dec 10 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Philibert Artigiano M.D.
Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/11/67
23C. PHYSICIAN'S NAME (Type): Philibert Artigiano M.D.
23D. ADDRESS: 2305 Mayfield Ave. Baltimore Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/14/67
24C. NAME of CEMETERY or CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc.
ADDRESS: 5305 Harford Rd.

VS 150-REV. 1/1/65

M-200

BIRTH NO. 67 11913

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11913

1. NAME OF DECEASED (Type or Print): MC GEE, Charles Roe

2. DATE AND HOUR OF DEATH: 12-11-67 | 9:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Boulevard, Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 5302 Remmel Avenue

27-34

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Caucasian	Divorced	6-20-98	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Track Crew Forman	Rail Road	North Carolina	U.S.A.

13. FATHER'S NAME: David McGee

14. MOTHER'S MAIDEN NAME: Elizabeth Maiden name unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	2-6-17 to 10-27-19PN	165-06-20-98	VA Hospital Records	3900 Loch Raven Blvd, Balto, Md 21218

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 433.01 + 260 X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Arrest

DUE TO

(B) ASCVD

~~DUE TO~~

(C) Diabetes mellitus.

years

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(R) CVA

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-29-67 19 to 12-11 1967, that (I) (we) last saw the deceased alive on 12-11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Monica M Buckley

M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12-11-67

23C. PHYSICIAN'S NAME (Type): MONICA M. BUCKLEY, M.D.

23D. ADDRESS: 3900 Loch Raven Blvd. VA Hospital, Baltimore, Md. 21218

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/14/67.	Baltimore National Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 12 1967	Robert E. Farley M.D.	Leonard J. Ruck, Inc.	Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

43-62-06 GG 1

BIRTH NO. 7-616 67 11914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11914

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JESSAMINE FARBER

2. DATE AND HOUR OF DEATH: DEC. 10, 1967 | 7 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 11-01
D. STREET ADDRESS (If rural, give location): 218 E. PRESTON ST. # 21202

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 11-19-1892
9. AGE (In years last birthday): 75
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry VanDyke JOHNS
14. MOTHER'S MAIDEN NAME: LENA MARIE STEINMEYER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-05-1035A
17. INFORMANT: RECORDS: BCH 4940 EASTERN AVE. BALTIMORE 21224, MD.
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 491X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia — 14 days
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Atherosclerotic cerebrovascular disease — >10 years

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/27 1967 to 12/10 1967, that (I) (we) last saw the deceased alive on 12/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Benjamin Lechner, MD. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: Dec. 10, 1967
23C. PHYSICIAN'S NAME (Type): DR. BENJAMIN LECHNER M.D.
23D. ADDRESS: BALTIMORE 21224, MARYLAND BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-13-67
24C. NAME of CEMETERY or CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Tankey M.D.
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.
ADDRESS: 4905 York Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M-460

M.E. CASE NO. 67 11915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11915

1. NAME OF DECEASED (Type or Print): Carl H. Miller

2. DATE AND HOUR OF DEATH: Dec. 9, 1967 1:00 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5815 Lochlea Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21209 27-15
D. STREET ADDRESS (If rural, give location): 5815 Lochlea Road

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 5/25/1906
9. AGE (In years last birthday): 61
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10B. KIND OF BUSINESS OR INDUSTRY: Westinghouse Elec.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Miller
14. MOTHER'S MAIDEN NAME: Elsie Young

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-14-3034
17. INFORMANT: Mrs. Mildred C. Miller
ADDRESS: (Same)

MEDICAL CERTIFICATION

I
1B. 420.1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary Occlusion — 2 hrs
DUE TO
(B) Hypertensive CVD.
DUE TO
(C) Ventricular Fibrillation

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Coronary Insufficiency

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 7 1967 to Dec 9 1967, that (I) (we) last saw the deceased alive on Dec 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Dr Thos Y Abbott M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12-11-67
23C. PHYSICIAN'S NAME (Type): Thomas Abbott M.D.
23D. ADDRESS: 4509 Liberty Heights

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/12/67
24C. NAME of CEMETERY or CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co.
ADDRESS: 4905 York Road Baltimore, Md. 21212

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. H-530

M.E. CASE NO. 67 11916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11916

1. NAME OF DECEASED (Type or Print): Mildred F. Hunt

2. DATE AND HOUR OF DEATH: Dec. 9, 1967 11:45 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 320 Broxton Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-12
D. STREET ADDRESS (If rural, give location): 320 Broxton Road

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 8/13/1890
9. AGE (In years last birthday): 77
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin F. Franklin
14. MOTHER'S MAIDEN NAME: Elizabeth Gardner

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-01-6379-B
17. INFORMANT: Charles N. Hunt
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C-V-D — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from March 28 1967 to December 9 1967 that (I) (~~we~~) last saw the deceased alive on December 8 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Newland E. Day M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: December 11, 1967
23C. PHYSICIAN'S NAME (Type): Newland E. Day M.D.
23D. ADDRESS: 4 E. 33rd St.

24A. BURIAL CREMATION, REMOVAL (Specify): Rem.-Burial
24B. DATE: 12/13/67
24C. NAME of CEMETERY or CREMATORY: New Mount Ida
24D. LOCATION (City, town, or county) (State): Troy, New York

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Tarbeyma
25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co.
ADDRESS: 4905 York Road Baltimore, Md. 21212

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. H-220 67 11917

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11917

1. NAME OF DECEASED (Type or Print): GRACE HUGHES

2. DATE AND HOUR OF DEATH: 10 DEC 67 | 12:35 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 9-06

D. STREET ADDRESS (If rural, give location): 2709 HUGO AVE

5. SEX: F

6. RACE: NEG.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 5-25-90

9. AGE (In years last birthday): 77

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: —

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: HELEN HUGHES ADDRESS: 2709 HUGO AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ASCUD ARRYTHAMIA + — Yrs +

DUE TO (B) DIGITALIS TOXICITY — wks —

DUE TO (C) Diabetes Mellitus — yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?: —

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 6 DEC 1967 to 10 Dec 1967, that ~~(I)~~ (we) last saw the deceased alive on 9 Dec 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Salvatore R. Donohue M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 10 Dec 67

23C. PHYSICIAN'S NAME (Type): SALVATORE R. DONOHUE M.D.

23D. ADDRESS: MERCY HOSP.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/14/67

24C. NAME of CEMETERY or CREMATORY: MT AUBURN CEM.

24D. LOCATION (City, town, or county) (State): BALTO., MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: WM C. MARCH ADDRESS: 928 E NORTH AVE

VS 150-REV. 1/1/65

50-71-01 LB 1

RELEASED ON APPROVAL OF MEDICAL EXAMINER, MR. MASON.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. W-362 67 11918

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11918

1. NAME OF DECEASED (Type or Print): BESSIE F. WATERS — BESSIE F. WATERS

2. DATE AND HOUR OF DEATH: 12-10-67 8:15PM — 10 DECEMBER, 1967 8:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224 — 31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): VALLEY FORGE ROAD — 53-00
D. STREET ADDRESS (If rural, give location): RANDALLSTOWN

5. SEX: FEMALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 8-21-14
9. AGE (In years last birthday): 53
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL DAVIS DEC.
14. MOTHER'S MAIDEN NAME: EMMA GROSS DEC.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS: BALTIMORE CITY HOSPITALS ADDRESS 4940 EASTERN AVE., BALTO., MD. 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) — E916.0 — 38% full thickness burns — 5 days

(a) DUE TO: (A) RENAL FAILURE — 5 days.

(b) DUE TO: ~~BURN~~

(c)

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY CHIEF OR ASST. MEDICAL EXAMINER — M.D.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): HOME
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Valley Forge Rd - Balto. Co 53-00
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12-10-67 8:15PM
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☑
21F. HOW DID INJURY OCCUR? On living room sofa. Subject was alcoholic and smoked

22. I certify that (I) (this hospital) attended the deceased from 6 DECEMBER 1967 to 10 DECEMBER 1967, that (I) (we) last saw the deceased alive on 10 DECEMBER, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Daniel D. Foote M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 10 DECEMBER, 1967
23C. PHYSICIAN'S NAME (Type): DANIEL D. FOOTE M.D.
23D. ADDRESS: BALTIMORE CITY HOSPITALS, 4940 EASTERN AVE., BALTO., MD. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/15/67
24C. NAME of CEMETERY or CREMATORY: St THOMAS CEMETERY
24D. LOCATION (City, town, or county) (State): RANDALLSTOWN, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: Robert E. Tankey, Mus
25C. FUNERAL DIRECTOR: WM C MARCH
ADDRESS: 928 E. NORTH AVE.

VS 150-REV. 1/1/65

N 948.2

B-266

BIRTH NO. 67 11919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11919

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Nancy Booker

2. DATE AND HOUR OF DEATH: 12-9-67 4:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2007 Guilford Ave.

12-04

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): separated
8. DATE OF BIRTH: 4-4-1897
9. AGE (In years last birthday): 70
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cumberland, Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Monroe
14. MOTHER'S MAIDEN NAME: Mary D. Hill

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Bowman Monroe
ADDRESS: 2007 Guilford Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

1B. 4 20 1

(A) Myocardial Infarction — 12 hrs:

DUE TO

(B) Arteriosclerotic Heart disease. — 9 mths:

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): None
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 28th Feb 1967 to 28th Nov 1967, that (I) (we) last saw the deceased alive on 28th Nov 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alvin Thompson M.D. — Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/12/67
23C. PHYSICIAN'S NAME (Type): Alvin Thompson M.D.
23D. ADDRESS: 1856 N. Wolfe St. Baltimore.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-13-67
24C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cemetery
24D. LOCATION (City, town, or county) (State): Anne Arundel Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 12 1967
25B. NAME OF REGISTRAR: R. L. & E. Fabian M.D.
25C. FUNERAL DIRECTOR: Randolph J. Collick
ADDRESS: 2431 E. Oliver St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-620 67 11920

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11920

1. NAME OF DECEASED (Type or Print): ROBERT MARTIN TUREK

2. DATE AND HOUR OF DEATH: Dec 10 1967 | 3.30A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3406 HATTON RD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-20

D. STREET ADDRESS (If rural, give location): 3406 HATTON ROAD

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	MARRIED	JAN 8, 1911	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Pa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH

14. MOTHER'S MAIDEN NAME: SONIA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO. 577-14-5471

17. INFORMANT: Wife ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion ABCVD. — 2 yr.

DUE TO

(B) aortic aneurysm — 2 yr.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Prostatic Hypertrophy — 2 yr.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 1965 to Dec 10 1967, that (I) (we) last saw the deceased alive on Dec 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Milton B. Kress M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Dec 10, 1967

23C. PHYSICIAN'S NAME (Type): MILTON B. KRESS M.D.

23D. ADDRESS: Medical Arts Bldg Balto, Md

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/11/67

24C. NAME of CEMETERY or CREMATORY: Chevrah Ameno

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Sylvan S. Levin & Son, Inc

ADDRESS: Garrison Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-260

BIRTH NO. 67-24575 67 11921

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11921

1. NAME OF DECEASED (Type or Print): Baby Boy Leasure, Steven Marshall

2. DATE AND HOUR OF DEATH: 12/11/67 7 45 am M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hospital of Maryland

46

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Balt. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 2405 Zion Rd 21227

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): —

8. DATE OF BIRTH: 12/10/67

9. AGE (In years last birthday): If Under 1 Yr. Months: Days: 1-7 If Under 24 Hrs. Hours: Min.: 16 min

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lester L. Leasure

14. MOTHER'S MAIDEN NAME: Ethel M. Deihl

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Lester L. Leasure, 2405 Zion Road 21227 ADDRESS

MEDICAL CERTIFICATION

18. 773.01

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Distress Syndrome — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/10/67 19 to 12/11/67 19, that (I) (we) last saw the deceased alive on 12/11/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S Noble M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-11-67

23C. PHYSICIAN'S NAME (Type): S. J. NOBLE M.D.

23D. ADDRESS: LUTHERAN HOSPITAL, 730 ASHBURTON ST.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-12-67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Tankey M.D.

25C. FUNERAL DIRECTOR: Howard H. Hubbard ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11922 Registered No. 67 11922

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HAMMED, SAM , SR.

2. DATE AND HOUR OF DEATH: DECEMBER 11, 1967 10:45A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 21227 Howard

C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~BALTIMORE~~ Elkridge 63-00

D. STREET ADDRESS (If rural, give location): 6209 WASHINGTON BLVD

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	MARRIED	07/24/93	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RESTAURANT-OWNER	RESTAURANT	~~SYRIA~~ Lebannon	USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 223-42-4051

17. INFORMANT: ST AGNES RECORDS ADDRESS: CATON & WILKENS AVES

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

162.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) TUMORAL CACHEXIA

DUE TO

(B) DISEMINATED METASTASIS

DUE TO

(C) BRONCHOGENIC CARCINOMA

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NEUMONITIS

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that XX (this hospital) attended the deceased from NOVEMBER 26 19 67 to DECEMBER 11 19 67, that XX (we) last saw the deceased alive on DECEMBER 11 19 67 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alejandro Mejia M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X

23B. DATE SIGNED: 12/11/67

23C. PHYSICIAN'S NAME (Type): ALEJANDRO MEJIA M.D.

23D. ADDRESS: SAINT AGNES HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12-13-67	Meadowridge Cemetery	Howard County, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Howard H. Hubbard, 4107 Wilkens Ave ADDRESS: 21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

14-42

BIRTH NO. 67 11923

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11923

1. NAME OF DECEASED (Type or Print): JOHN H. HOLZAPFEL

2. DATE AND HOUR OF DEATH: 12-10-67 | 1:15 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 3300 BEECH AVE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 13-06

D. STREET ADDRESS (If rural, give location): 3300 BEECH AVE

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 2-21-17

9. AGE (In years last birthday): 50

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CASHIER

10B. KIND OF BUSINESS OR INDUSTRY: DAIRY

11. BIRTHPLACE (State or foreign country): N. J.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES

(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 212-07-4266

17. INFORMANT: ADA F. HOLZAPFEL

ADDRESS: (SAME)

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 163X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of lung

INTERVAL BETWEEN ONset AND DEATH: ?

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-15 1967 to 12-10 1967, that (I) (we) last saw the deceased alive on 12-9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Reuben Hoffman M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-11-67

23C. PHYSICIAN'S NAME (Type): REUBEN HOFFMAN M.D.

23D. ADDRESS: 846 W. 36th St. BALTIMORE MD.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12-12-67

24C. NAME of CEMETERY or CREMATORY: NATIONAL

24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Paul E. Chenoweth

ADDRESS: 3617 Charles Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-520

BIRTH NO. 67 11924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11924

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Thomas William G

2. DATE AND HOUR OF DEATH: 12/10/67 | 12:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-03
D. STREET ADDRESS (If rural, give location): 1134 E 36th St

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: 10/11/78
9. AGE (In years last birthday): 89
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer Retired
10B. KIND OF BUSINESS OR INDUSTRY: Food
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Thomas
14. MOTHER'S MAIDEN NAME: Gesine Lang

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): ?
16. SOCIAL SECURITY NO.: 219-12-7778
17. INFORMANT: Albert Thomas, Nephew
ADDRESS: 3526 Greenmount

MEDICAL CERTIFICATION

1B. 420.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Arteriosclerotic Heart Dis — yrs
DUE TO Congestive Heart Failure
(B) ? Intestinal Obstruction — 2 wks
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/4 1967 to 12/10 1967, that (I) (we) last saw the deceased alive on 12/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: B. Ann Ward M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/10/67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/13/67
24C. NAME of CEMETERY or CREMATORY: IMMANUEL CEMETERY
24D. LOCATION (City, town, or county) (State): BALTIMORE MD

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
25B. NAME OF REGISTRAR: Robert E. Farley
25C. FUNERAL DIRECTOR: Ullrich Funeral Home
ADDRESS: 4210 BELAIR

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

T-520

67 11925

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11925

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM S. THOMAS

2. DATE AND HOUR PRONOUNCED DEAD: December 9, 1967 2:20 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

26-36

D. STREET ADDRESS (If rural, give location): 1401 Broening Highway

43/09

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Single	Oct. 29, 1948	19				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Food	Maryland.	U.S.A.

13. FATHER'S NAME: Regis Thomas

14. MOTHER'S MAIDEN NAME: Myrtle Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Regis Thomas

ADDRESS: 1401 Broening Hgwy.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E 823.4

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Hawkins Point east of Chemical Road

25-25

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12/9/67 1;25 P. m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? car went out of control and struck a telephone pole

22. I certify that I held an Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 12/9/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/12/67

23C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore Co., Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

24B. NAME OF REGISTRAR:

24C. FUNERAL DIRECTOR: Ullrich Funeral Home Dundalk, Md.

ADDRESS

VS 151-REV. 1/1/65

N869.2

H-255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11926 Registered No. X 67 11926

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN HACKMAN

2. DATE AND HOUR OF DEATH: 12/9/67 1:25 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Balto Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 77 Willow Spring Road #22

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	MARRIED	7/15/91	76				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
ELECTRICIAN	STEEL	Pennsylvania	USA

13. FATHER'S NAME: AUGUSTUS HACKMAN

14. MOTHER'S MAIDEN NAME: ANNIE BROWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WW I	213-07-3477	MRS IVY HACKMAN	77 WILLOW SPRING

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ASCVD

DUE TO

(B) Myocardial Infarction, acute

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Possible Carcinoma of GI

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTAINING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/7/67 19 to 12/9/67 19, that (I) (we) last saw the deceased alive on 12/9/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Dr. M L Kaufman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/9/67

23C. PHYSICIAN'S NAME (Type): DR.

23D. ADDRESS: M.D. 1213 Light Street Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
BURIAL	12/12/67	BEZAIR MEMORIAL	BEZAIR	MD

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 13 1967	Robert E. Farley M.D.	ULLRICH FUNERAL HOME	DUNDALK MD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-524

67 11927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11927

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MRS. ANNIE C. MANGELSO

2. DATE AND HOUR OF DEATH: 12/10/67 | 5 35 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: Balto Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

53-00

D. STREET ADDRESS (If rural, give location): 1509 CAVEL RD. #37

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 10-18-86

9. AGE (In years last birthday): 81

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: NICHOLAS MAURER

14. MOTHER'S MAIDEN NAME: MARY SCHULTZ.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 215-05-5535

17. INFORMANT: ALICE E. SMITH

ADDRESS: SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) ASCVD

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 12/10 12:20 AM 1967 to 12/10 1967, that (I) (we) last saw the deceased alive on 12/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fridjofur Bjornsson M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12-10 67

23C. PHYSICIAN'S NAME (Type): F. BJORNSSON M.D.

23D. ADDRESS: Maryland General Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12-13-67

24C. NAME of CEMETERY or CREMATORY: OAK LAWN CEM.

24D. LOCATION (City, town, or county) (State): 7225 EASTERN BLVD. BALTO. CO., MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Farkas

25C. FUNERAL DIRECTOR: Charles A. Geiler

ADDRESS: 901 S. CONKLING ST. BALTO., 21224, MD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11928 Registered No. 67 11928

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Sotheron - Miss Nellie

2. DATE AND HOUR OF DEATH: December 9-1967 1:45 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 91 Keswick

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Keswick
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore - Md - 21211
D. STREET ADDRESS (If rural, give location): 700 W. 40th Street

13-07

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never Married
8. DATE OF BIRTH: 1-20-1884
9. AGE (In years last birthday): 83 — 82 y/s
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): L.P.N.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Thomas Sotheron
14. MOTHER'S MAIDEN NAME: Jennie Hawkins

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-30-3894
17. INFORMANT: Rachel C. Gibson - R.N. ADDRESS:

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Aspiration pneumonia — Days
(B) DUE TO: Severe ASCVD
(C): Parkinsonism — Years

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-6 1964 to 12-9 1967, that (I) (we) last saw the deceased alive on 12-9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R K Gundry M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12-11-67
23C. PHYSICIAN'S NAME (Type): R K GUNDRY M.D.
23D. ADDRESS: 2 W University Pkwy - 21218

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/12/67
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: Wm. Tickner Sons
ADDRESS: Butler Md. Pa.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
H-125

67 11929 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11929

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM Melvin HOPKINS

2. DATE AND HOUR PRONOUNCED DEAD: December 10, 1967 9:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 506 S. Hanover St. (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-01
D. STREET ADDRESS (If rural, give location): 506 S. Hanover St.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: June 5,1906
9. AGE (In years last birthday): 61yrs.
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintanace
10B. KIND OF BUSINESS OR INDUSTRY: St. Mary's Seminary
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S. A.

13. FATHER'S NAME: George Hopkins
14. MOTHER'S MAIDEN NAME: Ada ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 217-07-0465
17. INFORMANT: Jeanette Dring
ADDRESS: Whitemarsh Md. Gunpowder Rd.

MEDICAL CERTIFICATION

1B. 4221

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 12/10/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12/12/67
23C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cem.
23D. LOCATION (City, town, or county) (State): Trump's MillRd.Balto.Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: KRAUSE FUNERAL HOME
ADDRESS: 1216S.CharlesSt

VS 151-REV. 1/1/65

K-55-b

67 11930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11930

BIRTH NO.

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): S. MOE KAMINSKY

2. DATE AND HOUR OF DEATH: DEC 10, 1967 | 7:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6114 BENHURST ROAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-20
D. STREET ADDRESS (If rural, give location): 6114 BENHURST RD

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: OCT 6, 1910
9. AGE (In years last birthday): 57
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): EXEC.
10B. KIND OF BUSINESS OR INDUSTRY: CORP
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LOUIS
14. MOTHER'S MAIDEN NAME: ETTA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 215-30-8562
17. INFORMANT: WIFE
ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
420.1	(A) M I	1 day
	(B) DUE TO Hypertension	9 months
	(C)	

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/6 1946 to 12/10 1967, that (I) (we) last saw the deceased alive on 12/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/11/67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS: 4000 W. Northern Parkway

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/12/67
24C. NAME of CEMETERY or CREMATORY: CHIZUK AMUNO
24D. LOCATION (City, town, or county) (State): BALTO MD

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Sylvan S. Levin & Son, Inc
ADDRESS: Garrison Md

VS 150-REV. 1/1/65

B-500

BIRTH NO. 67 11931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11931

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): William Theodore Bowen

2. DATE AND HOUR OF DEATH: Dec. 9, 1967 | 4.00 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5306 Wendley Road
00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 28-04
D. STREET ADDRESS (If rural, give location): 5306 Wendley Road

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: Dec. 12, 1902
9. AGE (In years last birthday): 64
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper
10B. KIND OF BUSINESS OR INDUSTRY: Wooden & Co.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Theodore F. Bowen
14. MOTHER'S MAIDEN NAME: Ada E. Kirby

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-03-4488
17. INFORMANT: Mrs. Ada E. Bowen
ADDRESS: 5306 Wendley Road

MEDICAL CERTIFICATION

18. 331X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebro Vascul ar Accident — Acute
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this ~~hospital~~) attended the deceased from Dec 1 1958 to Dec 9 1967, that (I) (~~we~~) last saw the deceased alive on 12-9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C J Mendelis M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12/11/67
23C. PHYSICIAN'S NAME (Type): C J Mendelis M.D.
23D. ADDRESS: 2308 Edmondson Ave

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-12-1967
24C. NAME of CEMETERY or CREMATORY: Baltimore
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT. DEC 13 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: G. Howard Strong
ADDRESS: 3207 W. North Ave.,

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11932 Registered No. 67 11932

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Emma M. Wildmann

2. DATE AND HOUR OF DEATH: December 11, 1967 12 45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00

1611 S. Hanover St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 23-02

D. STREET ADDRESS (If rural, give location): 1611 S. Hanover St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widow	Jan. 20, 1886	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Balto. Md.	U S A

13. FATHER'S NAME: Henry Hartline

14. MOTHER'S MAIDEN NAME: Rose M. Vetters

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Mrs. Agnes England	615 Bruce St. 25

MEDICAL CERTIFICATION

18.	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary Thrombosis	Several hours
	(B) DUE TO Generalized arteriosclerosis	2-3 years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		no	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/26 1967 to 12/11 1967, that (I) (we) last saw the deceased alive on 12/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Harry Deibel M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/11/67

23C. PHYSICIAN'S NAME (Type): Harry Deibel M.D.

23D. ADDRESS: 1226 S. Hanover Street Balto, Md. 21230

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12 14 67	Western	Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 13 1967	Robert E. Farley M.D.	Mc Cully	130 E. Fort Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11933 Registered No. 67 11933

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FEELEMYER, MAUDE V.

2. DATE AND HOUR OF DEATH: 12/08/67 5:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21229 25-31

D. STREET ADDRESS (If rural, give location): 683 S. WICKHAM ROAD

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 07/05/86

9. AGE (In years last birthday): 81

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: ROBERT BEALL

14. MOTHER'S MAIDEN NAME: MARY (HOBBS)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 212-05-7811A

17. INFORMANT: ST AGNES HOSPITAL RECORDS

ADDRESS: WILKENS & CATON AVES.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis

DUE TO

(B) Adenocarcinoma of Colon

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 24, 19 67 to DECEMBER 8, 19 67, that (I) (we) last saw the deceased alive on DECEMBER 8, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Raphael C. Myers Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12/8/67

23C. PHYSICIAN'S NAME (Type): RAPHAEL C. MYERS JR. M.D.

23D. ADDRESS: ST AGNES HOSPITAL- WILKENS & CATON AVES

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/12/67

24C. NAME of CEMETERY or CREMATORY: MT. OLIVET

24D. LOCATION (City, town, or county) (State): FREDERICK Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Foxwell

25C. FUNERAL DIRECTOR: E.S. MacNabb

ADDRESS: 301 Frederick Rd, Balto. Md 21228

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530

67 11934 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 11934

BIRTH NO.

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): A. PRESTON SMITH

2. DATE AND HOUR PRONOUNCED DEAD: Died; 12/11/67 | 11:20 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 42 Sinai Hospital D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-18
D. STREET ADDRESS (If rural, give location): 3735 Manchester Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	May 11, 1907	60				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cable Inspecter	Western Electric	Chestertown, Md.	

13. FATHER'S NAME: John A. Smith

14. MOTHER'S MAIDEN NAME: Mary Anna Sanford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-03-5775

17. INFORMANT: Mrs. Lucille O. Smith

ADDRESS: same address

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 926 X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot wound of the head

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home ?

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3735 Manchester Ave.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12 11 67 ? m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Subject shot himself

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [XX] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Edw F. Wilson M.D.

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: December 11, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/14/67

23C. NAME of CEMETERY or CREMATORY: Mt. Olivet Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

24B. NAME OF REGISTRAR: Robert E. Faulkner

24C. FUNERAL DIRECTOR: Wm. J. Tichnor & Sons

ADDRESS: Balto. Md. North Pa.

VS 151-REV. 1/1/65

V836.4

1
B-260

67 11935 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11935

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES PBAKER (JAMES P. BAKER)

2. DATE AND HOUR PRONOUNCED DEAD: December 10, 1967 | 8:30 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 35 Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 618 Wilson Ave. # 21224,

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	May 27, 1905	62				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman	Arundel-Brooks Corp.	Baltimore , Md.	U.S.A.

13. FATHER'S NAME: James P. Baker

14. MOTHER'S MAIDEN NAME: Mamie Stanton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	———	216-07-5364	Louise R. Baker	Same.

MEDICAL CERTIFICATION

1B. E 830.0

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia, complicating fracture of ribs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	YES

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Garage

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Arundel=Brooks Corp. Garage 2-03

21D. TIME OF INJURY (APPROX.): (Month) 11 (Day) 21 (Year) 67 (Hour) 8:30 a m.

21E. INJURY OCCURRED: WHILE AT WORK [X] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Struck by cement truck in garage

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 11, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12- 14 -67	Oak Lawn Cemetery	7225 Eastern Blvd.Ba.Co.,Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 13 1967	Robert E. Fahrney	Charles S. Geiler	901 S. Conkling St. Balto., 21224, Md.

VS 151-REV. 1/1/65

N 807.2

I-521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

67 11936

Registered No. 67 11936

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Rita INGRAM

2. DATE AND HOUR OF DEATH: 12.7.67 | 11 30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital Baltimore Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY: Allegany Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Cresaptown

D. STREET ADDRESS (If rural, give location): 51-00

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 11.20.19

9. AGE (In years last birthday): 48

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): FROSTBURG, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: OWEN McATEER

14. MOTHER'S MAIDEN NAME: MARGARET GREEN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: MR. ROBERT LEE SNOEBERGER, ADDRESS CRESAPTOWN MARYLAND

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Metastasis — INTERVAL BETWEEN ONset AND DEATH: 1 yr

DUE TO

(B) Carcinoma of Breast

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: None

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11.25.67 19 67 to 12.7 19 67, that (I) (we) last saw the deceased alive on 12.7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Rogers Pierson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12.7.67

23C. PHYSICIAN'S NAME (Type): Dr Rogers Pierson M.D.

23D. ADDRESS: University Hospital Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12/11/67

24C. NAME of CEMETERY or CREMATORY: ST. MICHAEL'S CEMETERY

24D. LOCATION (City, town, or county) (State): FROSTBURG, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Faber

26C. FUNERAL DIRECTOR: MARILOU M. SOWERS, Marilou M. Sowers

ADDRESS: HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
K-656
R-320

67 11937 BALTIMORE CITY HEALTH DEPARTMENT 67 11937

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. Registered No. X

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARGARET E. KRAMER - RITZ

2. DATE AND HOUR PRONOUNCED DEAD: December 11, 1967 3:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Baltimore City Hospital (DOA)

31/29

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland 21221 B. COUNTY: Balto Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore (Essex) 53-00
D. STREET ADDRESS (If rural, give location): 5 ~~Hoxlers~~ Goellers Avenue

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: May 14, 1905
9. AGE (In years last birthday): 62
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse
10B. KIND OF BUSINESS OR INDUSTRY: Spring Grove St. Hosp.
11. BIRTHPLACE (State or foreign country): Deals Island, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ~~R~~Parks
14. MOTHER'S MAIDEN NAME: Mary Crocket

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-16-4448
17. INFORMANT: Edward C. Ritz, son, ADDRESS: 7412 Kalton Court 21208

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 443X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic and Hypertensive ~~XXXX~~ Cardiovascular Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 12/12/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12/14/67
23C. NAME of CEMETERY or CREMATORY: Baltimore Cemetery
23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
24B. NAME OF REGISTRAR: Robert E. Fahey
24C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 3331 Brehms Lane

VS 151-REV. 1/1/65

M-360

BIRTH NO. 67 11938

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11938

1. NAME OF DECEASED (Type or Print): JAMES L. MOUDRY

2. DATE AND HOUR OF DEATH: Dec. 9, 1967 8:30 p. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): OO 103 E. 22nd St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-04

D. STREET ADDRESS (If rural, give location): 103 E. 22nd St.

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: 6/19/09

9. AGE (In years last birthday): 58

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Beth. Steel Co.

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): yes

(If yes, give war or dates of service): WW 2-Army

16. SOCIAL SECURITY NO.: 219-03-1348

17. INFORMANT: Catherine Healey Moudry, wife

ADDRESS: 2825 E. Madison St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I 322.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO Coronary Occlusion — Immediate

(B) DUE TO Hypertension — 2 years

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Alcoholism — 10 years

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1964 19 to 1967 19, that (I) (~~we~~) last saw the deceased alive on Oct. 7, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Benj. R. Moses M.D.

Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-11-67

23C. PHYSICIAN'S NAME (Type): Dr. Benjamin Moses M.D.

23D. ADDRESS: 448 N. Luzerne Ave.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/13/67

24C. NAME of CEMETERY or CREMATORY: Balto. Nat. Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.

ADDRESS: 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

P-420

67 11939 BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11939

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALBERT M. ~~PAULAS~~ - PAULUS

2. DATE AND HOUR PRONOUNCED DEAD: December 9, 1967 9:30 P. M.

CERTIFICATE AMENDED 12-20-67

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 2847 Mayfield Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-01
D. STREET ADDRESS (If rural, give location): 2847 Mayfield Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	married	11/27/1896	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Inspector	Rowan Comp. Co.	Baltimore, Md.	

13. FATHER'S NAME: John Paulus

14. MOTHER'S MAIDEN NAME: Mary Dumler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 215-07-1852A

17. INFORMANT: Mabel Wyatt Paulus, wife, above — ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection [X] Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE [signature] M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

DATE SIGNED: 12/10/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/13/67	Gardens of Faith Cem.	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 13 1967	Robert E. Falkenhe	Schimunek Funeral Home, Inc.	3331 Brehms Lane

VS 151-REV. 1/1/65

T-416 1
D-126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11940 Registered No. 67 11940

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Talbert William E. (or William E. Davis)

2. DATE AND HOUR OF DEATH 12/9/67 9:44 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
33 JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
4313 SEIDEL AVE.
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE MARYLAND 26-02
D. STREET ADDRESS (If rural, give location)

5. SEX M
6. RACE W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M
8. DATE OF BIRTH 3/15/12
9. AGE (In years last birthday) 55
If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cab driver
10B. KIND OF BUSINESS OR INDUSTRY DIAMOND CAB Co.
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME HARRY Talbert
14. MOTHER'S MAIDEN NAME DAVIS, SADIE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-03-0278
17. INFORMANT CHART
ADDRESS

MEDICAL CERTIFICATION

18. 410X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardiac arrest occurring ~ 19 days
DUE TO
(B) General debilitation and hypotension following mitral commissurotomy
DUE TO
(C) for marked mitral stenosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
① Chronic lung disease
② Gangrene of ① leg and both hands
③ Acute gangrenous cholecystitis & probable sepsis ~ 5 days

19A. DATE OF OPERATION 11/21/67 12/1/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ① Mitral stenosis ② gangrene of ① lower leg
20A. AUTOPSY? (Yes or No) yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/28 1967 to 12/9 1967, that (I) (we) last saw the deceased alive on 12/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Mark B. Orringer M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED 12/9/67.
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify) Burial
24B. DATE 12/12/67
24C. NAME of CEMETERY or CREMATORY Meadowridge Mem. Park
24D. LOCATION (City, town, or county) (State) Elkridge, Md.

25A. DATE REC'D BY HEALTH DEPT. DEC 13 1967
25B. NAME OF REGISTRAR Robert E. Farkas
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.
ADDRESS 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-45 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11941 Registered No. 67 11941

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HOLLAND ALBERT C.

2. DATE AND HOUR OF DEATH: 12-9-67 11:20 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 7-01

D. STREET ADDRESS (If rural, give location): 2808 ASHLAND AVENUE

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	MARRIED	08-28-14	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. STEEL WORKER

10B. KIND OF BUSINESS OR INDUSTRY: Garies Erectors Co

11. BIRTHPLACE (State or foreign country): Baltimore MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ELMER HOLLAND

14. MOTHER'S MAIDEN NAME: BARBARA GUNTHER MARYLAND

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-05-8128

17. INFORMANT: Leona Babiszak Holland, wife, above ADDRESS

MEDICAL CERTIFICATION

1B. 023X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CHF

DUE TO Effusion, Ascitic

(B) Acute Confluent Bronchopneumonia

DUE TO

(C) PCJ

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-24-67 1967 to 12-9 1967, that (I) (we) last saw the deceased alive on 12-9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Raul V. Desquitado M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-9-67

23C. PHYSICIAN'S NAME (Type): RAUL V. DESQUITADO M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

RAUL V. DESQUITADO UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/13/67	Gardens of Faith Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. ADDRESS: 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
J-520

67 11942 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11942

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES J. JONES Sr.

2. DATE AND HOUR PRONOUNCED DEAD: December 9, 1967 | 1:10 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): St. Agnes Hospital (DOA)

40/92

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-04
D. STREET ADDRESS (If rural, give location): 4526 Manor View Road

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): married
8. DATE OF BIRTH: 2/14/1933
9. AGE (In years last birthday): 34
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Superintendant
10B. KIND OF BUSINESS OR INDUSTRY: Zone Marking Co.
11. BIRTHPLACE (State or foreign country): Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Doris Mason Jones, wife, above
ADDRESS

MEDICAL CERTIFICATION

18. 422.1

CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardiovascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 12/9/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12/12/67
23C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery
23D. LOCATION (City, town, or county) (State): Woodlawn, Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
24B. NAME OF REGISTRAR: Robert E. Farkyna
24C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 2601 E. Madison St.

VS 151-REV. 1/1/65

D-623

BIRTH NO. 67 11943

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11943

1. NAME OF DECEASED (Type or Print): Thomas Lucyan Drozd

2. DATE AND HOUR OF DEATH: December 11, 1967 — 1:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home 240 South Ann Street

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 21231 2-02

D. STREET ADDRESS (If rural, give location): 240 South Ann Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Dec, 18, 1886

9. AGE (In years last birthday): 80

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wood Tool Maker

10B. KIND OF BUSINESS OR INDUSTRY: Hopeman Bros, Inc.

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lucyan Drozd

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-05-1786

17. INFORMANT: Bernard F. Drozd 332 S. Giles St, Belair, Md. ADDRESS 21014

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 + 260X

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) COronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 12/11/67

DUE TO

(B) Arteriosclerotic Cardiovascular Disease with Coronary Insufficiency and Angina Pectoris — 1/8/61

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Maturity Onset Diabetes — 1961

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: None

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 8 19 61 to December 11 19 67, that (I) (we) last saw the deceased alive on Aug. 18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Joseph F. Drenga M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Dec. 12, 1967

23C. PHYSICIAN'S NAME (Type): Joseph F. Drenga, M.D. M.D.

23D. ADDRESS: 209 S. Chester Str Baltimore, Md. 21231

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/15/67

24C. NAME of CEMETERY or CREMATORY: St. Stanislaus Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: George A. Weber ADDRESS: 705 South Ann Street

George A. Weber

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11944 Registered No. 67 11944

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM M. LEARY (LARRY) (LOWERY)

2. DATE AND HOUR OF DEATH: 12/12/1967 5 30 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MARYLAND B. COUNTY: 7-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE D. STREET ADDRESS (If rural, give location): 814 N. DURHAM ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	NEGRO	Widow	8-8-04	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Elizabeth City, N.C.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Leary

14. MOTHER'S MAIDEN NAME: Harriet Banks

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 239-16-5401

17. INFORMANT: Hilda Fowlkes ADDRESS: 814 N. Durham Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 162.1 (A) Bronchogenic Carcinoma

DUE TO (B)

DUE TO (C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 11 1967 to December 12 1967, that (I) (we) last saw the deceased alive on December 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John T. Flaherty M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Dec 12, 1967

23C. PHYSICIAN'S NAME (Type): John T. Flaherty M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/17/67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State): Elizabeth City, N.C.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Jackson

25C. FUNERAL DIRECTOR: WM C MARCH ADDRESS: 928 E. NORTH AVE.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

L-256 67 11945

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11945

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): REV. ROBERT JOSEPH LOCHNER

2. DATE AND HOUR PRONOUNCED DEAD: December 9, 1967 2:20 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balt Co
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 8501 Loch Raven Road (Blvd)

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Never Married	July 22, 1930	37				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Priest	Church	Maryland	U. S. A.

13. FATHER'S NAME: George John Lochner

14. MOTHER'S MAIDEN NAME: Margaret Mundy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	National Guard	218-26-4888	Mrs. Margaret Lochner	414 Alabama Road Towson, Maryland 21204

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E823.4

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Injuries

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Hawkins Point east of Chemical Road 25-05

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12/9/67 1:25 A. m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? car went out of control and struck a telephone pole

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 12/9/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	Dec. 13, 1967	Mt. Maria Genetery	Towson, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 13 1967	Robert E. Farley M.D.	Wm. Cook-Brooks Towson,	1050 York Raod Towson, Md. 21204

VS 151-REV. 1/1/65

N 869.2 DEC 1 1967

(5) 1

B-650

BIRTH NO. 67 11946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11946

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BROWN, ROSE WILHELMINA

2. DATE AND HOUR OF DEATH: 12/11/67 | 11:10 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 20-02

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21223

D. STREET ADDRESS (If rural, give location): 543 SOUTH LONGWOOD STREET

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 01/08/96

9. AGE (In years last birthday): 71

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: AUGUST WITZ

14. MOTHER'S MAIDEN NAME: LENA FRANK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Sylvester Brown-Same ADDRESS: AVES ST AGNES HOSP. RECORDS-WILKENS & CATON

MEDICAL CERTIFICATION

18. 4201 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardiogenic Shock

DUE TO

(B) Acute Myocardial Infarction

DUE TO

(C) A.S.C.V.D.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from DECEMBER 10, 19 67 to DECEMBER 11, 19 67, that (I) (we) last saw the deceased alive on DECEMBER 11, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alejandro Mejia M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): ALEJANDRO MEJIA M.D.

23D. ADDRESS: St. Agnes Hospital

24A. BURIAL CREMATION REMOVAL (Specify): Burial

24B. DATE: 12/15/67

24C. NAME of CEMETERY or CREMATORY: Woodlawn Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Witzke F. D. - 4101 Edmondson Ave. ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
5-530

BIRTH NO. 67 11947

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11947

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CATHERINE SMITH

2. DATE AND HOUR PRONOUNCED DEAD: December 12, 1967 | 6:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 2537 W. Fayette Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-0-02
D. STREET ADDRESS (If rural, give location): 2537 W Fayette Street

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARREED
8. DATE OF BIRTH: 6-29-1915
9. AGE (In years last birthday): 52
If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): CHERAW, SOUTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN R. BRIDGES
14. MOTHER'S MAIDEN NAME: MAGGIE BRIDGES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: -0-
17. INFORMANT: Mr. Floyd Smith
ADDRESS: 2537 W. Fayette St.

MEDICAL CERTIFICATION

1B. 4221

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardiovascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz, M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 12/12/67

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
23B. DATE: 12-16-67
23C. NAME of CEMETERY or CREMATORY: Mount Auburn Cem.
23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: MORTON & DYETT F.H.
ADDRESS: 1701 Laurens St.

VS 151-REV. 1/1/65

P-400 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11948 Registered No. 67 11948

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SARAH POWELL

2. DATE AND HOUR OF DEATH: Dec 10. 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00

604 Cherry Crest Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 25-32

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 604 Cherry Crest Road

5. SEX: F.

6. RACE: N.

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: Nov 28, 1902

9. AGE (In years last birthday): 65

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): BOYKINS, VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JULIUS POWELL

14. MOTHER'S MAIDEN NAME: SALLIE POWELL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Virginia Baskerville ADDRESS: 635 Hillvill

MEDICAL CERTIFICATION

18. 260 X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) C. Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

(B) arterio sclerosis — 15 years

DUE TO

(C) Diabetes mellitus — 8 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 15, 1949 to December 10, 1967, that (I) (we) last saw the deceased alive on December 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: John E. T. Camper M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12-11-67

23C. PHYSICIAN'S NAME (Type): JOHN E. T. CAMPER M.D.

23D. ADDRESS: 639 N CAREY ST.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12-13-67

24C. NAME of CEMETERY or CREMATORY: Mount Auburn Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Talley M.D.

25C. FUNERAL DIRECTOR: MORTON & DYETT F.H. ADDRESS: 1701 Laurens St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

J-525

67 11949 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 11949

BIRTH NO.

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ELLA V. JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD: December 11, 1967 | 12:30 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 431 E. LaFayette St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12 05

D. STREET ADDRESS (If rural, give location): 431 E. LaFayette St.

5. SEX	6. RACE	7. MARITAL STATUS (NEVER MARRIED, MARRIED, WIDOWED, DIVORCED) (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Colored	Widow	2-22-1900	67				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: Isaac Watkins

14. MOTHER'S MAIDEN NAME: Amelia Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-01-58700

17. INFORMANT: Mrs. Blanche M. Davis ADDRESS: 431 E. Lafayette Av-

MEDICAL CERTIFICATION

1B. 4221

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 11, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12-15-67	Mt. Calvary Cemetery	A.A. Co., Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 13 1967	Robert E. Farley M.D.	Marshall W. Jones, Jr.	1735 Harford Ave. 21213

VS 151-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. L-220 67 11950

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11950

1. NAME OF DECEASED (Type or Print): ANNA L LUCAS

2. DATE AND HOUR OF DEATH: DEC 11 1967 | 1:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00

6305 EVERALL AVE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-05

D. STREET ADDRESS (If rural, give location): 6305 EVERALL AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	CAUCASIAN	NEVER MARRIED	FEB 12, 1918	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MACHINIST	KOPPERS CO.	BALTO, MD.	U.S.A.

13. FATHER'S NAME: LAWRENCE LUCAS

14. MOTHER'S MAIDEN NAME: MARCELLE MIKLAUSKI

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-09-4486

17. INFORMANT: NELLIE HEDLER

ADDRESS: 6305 EVERALL AVE. 21206

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 151X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal carcinoma

DUE TO

(B) Adenocarcinoma of

DUE TO

(C) the stomach

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 1967 to Dec. 11 1967, that (I) (we) last saw the deceased alive on Dec 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stanley Ankudas M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12.12.67

23C. PHYSICIAN'S NAME (Type): STANLEY ANKUDAS M.D.

23D. ADDRESS: 1101 MAIDEN CHOICE LANE, BALTO.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	12/14/67	HOLY REDEEMER CEM.	BALTO, MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 13 1967	Robert E. Fairbanks	DIPPEL BROTHERS INC.	7110 BELAIR RD BALTO. MD.

VS 150-REV. 1/1/65

1

K-620 67 11951

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11951

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARTIN F. KRAUS XXXXX

2. DATE AND HOUR PRONOUNCED DEAD: December 11, 1967 6:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 4609 Harcourt Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore XXXX$ 21214 27-01
D. STREET ADDRESS (If rural, give location): 4609 Harcourt Road

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: Dec. 11, 1893.
9. AGE (In years last birthday): 75
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Hospital Employee
10B. KIND OF BUSINESS OR INDUSTRY: (Balto. City)
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Kraus
14. MOTHER'S MAIDEN NAME: Anna Hannan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-40-7154
17. INFORMANT: Mrs. Verna Schillega
ADDRESS: (Same)

MEDICAL CERTIFICATION

1B. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 12/12/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12/14/67.
23C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cemetery
23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS

VS 151-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M-635 67 11952

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11952

1. NAME OF DECEASED (Type or Print): ESTELLA EVELYN MARTINI

2. DATE AND HOUR OF DEATH: December 11, 1967 5:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 6-01

D. STREET ADDRESS (If rural, give location): 2907 ORLEANS STREET

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW

8. DATE OF BIRTH: 02-24-14

9. AGE (In years last birthday): 53

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~None~~ Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? AMERICAN

13. FATHER'S NAME: JOHN J. COX

14. MOTHER'S MAIDEN NAME: JULIA FIRST

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-34-4175

17. INFORMANT: Mrs. Carolyn Trimble, Bottom Rd. Hyde, Md. ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 581.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) STATUS EPILEPTICUS

DUE TO

(B) HEPATIC COMA

DUE TO

(C) LAENNEC'S CIRRHOSIS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 7, 1967 to December 11 1967, that (I) (we) last saw the deceased alive on December 11, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED December 11, 1967

23C. PHYSICIAN'S NAME (Type): MIGUEL SANCHEZ-PALACIOS DR MIGUEL SANCHEZ PALACIOS M.D.

23D. ADDRESS: UNION MEMORIAL HOSPITAL THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/15/67.

24C. NAME of CEMETERY or CREMATORY: Gardens Of Faith Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214 ADDRESS

VS 150-REV. 1/1/65

Miguel Sánchez-Pacheco

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. G-623 67 11953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11953

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Florence M. Grossd

2. DATE AND HOUR OF DEATH: 12-11-67 1:50 pm.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 Franklin Square Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-02
D. STREET ADDRESS (If rural, give location): 3008 Rosekemp Ave

5. SEX: Female
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): ~~xxxxxxxxx~~ Widow
8. DATE OF BIRTH: 11-3-04
9. AGE (In years lost birthday): 63
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ITALY
12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: JOHN CARETTI
14. MOTHER'S MAIDEN NAME: LOUISA CARETTI

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Sang Bock Lee
ADDRESS: F. S. H

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 1211X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Metastatic lung ca
DUE TO
(B) Cervix ca — 4 years
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-6 1967 to 12-11 1967, that (I) (we) last saw the deceased alive on 12-11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sang Bock Lee M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12-11-67
23C. PHYSICIAN'S NAME (Type): Sang Bock Lee M.D.
23D. ADDRESS: Franklin Square Hosp

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/15/67.
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
25B. NAME OF REGISTRAR: Robert E. Tarkington
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS

VS 150-REV. 1/1/65

C-155

BIRTH NO. 67 11954

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11954

1. NAME OF DECEASED (Type or Print): Evelyn L. Chapman

2. DATE AND HOUR OF DEATH: Dec. 11, 1967 1:20 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2909 Berwick Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-07

D. STREET ADDRESS (If rural, give location): 2909 Berwick Ave.

5. SEX: female

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: May 30, 1894.

9. AGE (In years last birthday): 73

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nicholas Villone

14. MOTHER'S MAIDEN NAME: Pia Cervelli

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Daniel McGee, Wilmington, Del. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) 420.1 1. Infarction, Myocardial due to Arteriosclerotic coronary thrombosis

(B) DUE TO 2. Hypertensive CVD

(C) 3. Gen'l Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from May 15 1966 to Dec 11 1967, that (I) (we) last saw the deceased alive on Dec 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Donald W. Minter M.D.

Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/11/67

23C. PHYSICIAN'S NAME (Type): DONALD W MINTER M.D.

23D. ADDRESS: 3004 EVERGREEN AVE BALTO MD 21214

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 12/16/67.

24C. NAME of CEMETERY or CREMATORY: Mt. Paran Cemetery

24D. LOCATION (City, town, or county) (State): Harrisonville, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M. 620 1

B-622

BIRTH NO. 67 11955

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11955

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): WILHELMINA A. BROSEKER (Morris)

2. DATE AND HOUR OF DEATH: DEC. 12, 1967 | 8:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: CHURCH HOME + HOSPITAL
(If not in hospital or institution, give street address or location): BALTO, MD 21231
35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: ~~Balto~~ ~~CASA~~ AnneArundel Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21225 52.00
D. STREET ADDRESS (If rural, give location): 211 6th Ave.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 3-14-95
9. AGE (In years last birthday): 72
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hous ewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: WILLIAM ~~HENRY~~ Ritz
14. MOTHER'S MAIDEN NAME: JEANNIE HARR

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Roland Broseker
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

578X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhagic gastritis
DUE TO Pneumonia
Congestive heart failure

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11-27-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Gastrointestinal Bleeding
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12-12-67
23C. PHYSICIAN'S NAME (Type): Dr. S. MORRISON, Dr. R. SHIPLEY M.D.
23D. ADDRESS: Church Home & Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/16/67.
24C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto, Md. 21214
ADDRESS

VS 150-REV. 1/1/65

1
H-200

67 11956 BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11956

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN HAYS

2. DATE AND HOUR PRONOUNCED DEAD: December 11, 1967 | 2:30 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-04
D. STREET ADDRESS (If rural, give location): 1901 Wheeler Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored	Divored	12/17/17	49				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waiter	Hotel	Washington D.C.	U.S.A.

13. FATHER'S NAME: Charles W. Hays Sr.

14. MOTHER'S MAIDEN NAME: Hermine Harlow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): W.W.2

16. SOCIAL SECURITY NO.: 218-07-3947

17. INFORMANT: Mr Charles Hays ADDRESS: 1901 Wheeler Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E982.X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Stab wound of the neck and back

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Bar

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Monroe and North Ave. Pink Pony Bar 15-04

21D. TIME OF INJURY (APPROX.): (Month) 12 (Day) 10 (Year) 67 (Hour) 6:00 pm.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Subject stabbed in bar room

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Edward F. Wilson M.D.

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: December 11, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/14/67	Balt. National Cemetery	Baltimore CO. MD

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 13 1967	Robert E. Farley M.D.	Herbert E. Nutter	3035 W. North Ave.

VS 151-REV. 1/1/65

N829.2

W-401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11957 Registered No. 67 11957

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARGARET WILEY

2. DATE AND HOUR OF DEATH: 12/10/67 4:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto. City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 16-05
D. STREET ADDRESS (If rural, give location): 2428 Aurnah Avenue

5. SEX: F
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 7/25/1888
9. AGE (In years last birthday): 79
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): ARKANSAS
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Nathaniel Williams
14. MOTHER'S MAIDEN NAME: Sarah Madlock

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-56-2918-J1
17. INFORMANT: Mrs Eula Mae Watts — ADDRESS: 2428 Auranah Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 4911 — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia and pulmonary atelectasis — 7 days
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11:30 AM DEC 10 1967 to 4:45 PM DEC 10 1967, that (I) (we) last saw the deceased alive on 4 PM DEC 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: DEC 10 '67
23C. PHYSICIAN'S NAME (Type): SOO LOONG HONG M.D.
23D. ADDRESS: BON SECOURS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/16/67
24C. NAME of CEMETERY or CREMATORY: Rome Cemetery
24D. LOCATION (City, town, or county) (State): Okolone Arkansas

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Herbert E. Nutter — ADDRESS: 3035 W. North Avenue

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1 H-125 67 11958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11958

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HOPKINS, John Vernon

2. DATE AND HOUR OF DEATH: 12-11-67 | 10:45 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: ~~XXXXXX~~ Maryland B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-06

D. STREET ADDRESS (If rural, give location): 2850 N. Charles St.

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 3-16-1901

9. AGE (In years last birthday): 66

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Orthopedic Surgeon

10B. KIND OF BUSINESS OR INDUSTRY: Medical

11. BIRTHPLACE (State or foreign country): Colorado

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George P. Hopkins

14. MOTHER'S MAIDEN NAME: Ellen Guffey

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-09-2822

17. INFORMANT: Mrs. Julie F. Hopkins ADDRESS: Above

CAUSE OF DEATH

	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I 1B. 420.1 + 149.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Coronary thrombosis	2 hr.
ANTECEDENT CAUSES	(B) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Cancer of Tongue	3 yrs.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 12

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 16 1967 to Dec 11 1967, that (I) (we) last saw the deceased alive on Nov 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Joseph D B King M.D. Attending Phys. ☐ ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Dec. 12, 1967

23C. PHYSICIAN'S NAME (Type): Joseph D. B. King M.D.

23D. ADDRESS: 222 Cold Spring Lane, Balto., Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-14-67

24C. NAME of CEMETERY or CREMATORY: Woodlawn

24D. LOCATION (City, town, or county) (State): Woodlawn Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co. ADDRESS: 4905 York Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released as Non Med. for the Medical Examiners Office by Dr. ~~XXXXXXX~~ Palomino

Hopkins, Vernon 12.7.14.14

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B-630 67 11959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11959

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Roland H. Brady Jr

2. DATE AND HOUR OF DEATH: 12-12-67 | 4:05 P.M.

3. PLACE OF DEATH (IN BALTIMORE, MARYLAND): FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3910 Milford Ave. ~~Chesapeake Manor Home~~

28-41

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 7-29-1889
9. AGE (In years last birthday): 78
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Executive
10B. KIND OF BUSINESS OR INDUSTRY: Petroleum
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hamilton Brady
14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 442-01-1620
17. INFORMANT: Col. R.H. Brady Jr. ADDRESS: Alexandria, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — days.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes) or No: Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 8 1967 19 to Dec. 12 1967 19, that (I) (we) last saw the deceased alive on Dec. 12 1967 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X
23B. DATE SIGNED: Dec. 12 1967
23C. PHYSICIAN'S NAME (Type): PARVIZ K. AMID M.D.
23D. ADDRESS: Mercy Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-15-67
24C. NAME of CEMETERY or CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co. ADDRESS: 4905 York Rd.

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. U-524 67 11960

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11960

1. NAME OF DECEASED (Type or Print): Emil R. Unglaub

2. DATE AND HOUR OF DEATH: December 11, 1967 | 8:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 408 E. 28th St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 408 E. 28th St.

12-03

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Married	3/10/1882	85		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired-Printer	B & O RR	Ohio	U.S.A.

13. FATHER'S NAME: Gasper R. Unglaub

14. MOTHER'S MAIDEN NAME: Sophia C. Nelpph

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-05-6676

17. INFORMANT: Mrs. Sophia C. Unglaub — ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis. — 4 hr.
DUE TO
(B) Arteriosclerotic heart disease. — 5 yr.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Jan 28 1953 to Dec 11 1967, that (I) (~~we~~) last saw the deceased alive on 12/10 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Norman R. Freeman Jr. M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/13/67.

23C. PHYSICIAN'S NAME (Type): Norman R. Freeman, Jr. M.D.

23D. ADDRESS: 11 W. 29th St.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12/15/67	Druid Ridge	Pikesville, Balto.Co., Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR & ADDRESS: H.W. Jenkins & Sons Co. 4905 York Road Baltimore, Md. ~~XXXXXXX~~21212

VS 150-REV. 1/1/65

50-23-64 ED 1

BIRTH NO. M-620 67 11961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11961

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MORRIS, LUIZER LOUISA

2. DATE AND HOUR OF DEATH: 12/8/67 9:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4940 Eastern Ave. Baltimore, Maryland # 21224 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Chase 53-00
D. STREET ADDRESS (If rural, give location): Marshy Pt. Rd 21027

5. SEX: Female
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 7-4-84
9. AGE (In years last birthday): 83
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory Worker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Evans, Arden
14. MOTHER'S MAIDEN NAME: Gardner, Celia

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: BCH: Records 4940 Eastern Ave. Baltimore, Md.
ADDRESS: # 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MIOCARDIAL INFARCT — Minutes
DUE TO
(B) ARTERIOSCLEROSIS
DUE TO
(C)

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CATARACT OPERATION 11/30/67

19A. DATE OF OPERATION: 11/30/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: CATARACTS
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): no
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 10/10 1967 to 12/8 1967, that (I) (we) last saw the deceased alive on 12/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: E. Castro M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/8/67
23C. PHYSICIAN'S NAME (Type): E. CASTRO M.D.
23D. ADDRESS: 4940 Eastern Ave. Baltimore, Maryland BALTIMORE CITY HOSPITALS #21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-14-67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem
24D. LOCATION (City, town, or county) (State): Balto Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 18 1967
25B. NAME OF REGISTRAR: Charles E. Fackenthal
25C. FUNERAL DIRECTOR: Elroy O. Wilson 1000 Mantua St.
ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-362
W-346

67 11962 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11962

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LULA WATERS WATERS

2. DATE AND HOUR PRONOUNCED DEAD: December 6, 1967 | 5:30 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 831 Edmondson Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-03
D. STREET ADDRESS (If rural, give location): 831 Edmondson Ave.

5. SEX: Female
6. RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: May 18-1889
9. AGE (In years last birthday): 78
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Bessie Smith Same
ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 4221

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 6, 1967

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12-1467
23C. NAME of CEMETERY or CREMATORY: Mt Calvary Cat
23D. LOCATION (City, town, or county) (State): Brooklyn Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
24B. NAME OF REGISTRAR: Robert E. Foley M.D.
24C. FUNERAL DIRECTOR: Elroy Wilson
ADDRESS: 1000 Brantley Ave

VS 151-REV. 1/1/65

W-352

BIRTH NO. 67 11963

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11963

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MARGARET WHITING

2. DATE AND HOUR OF DEATH: December 9, 1967 | 8:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1831 EDMONDSON AVE
2001

5. SEX: F
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: May 4-1894
9. AGE (In years last birthday): 73
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Helen McMorris
ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Cerebral arteriosclerosis with encephalomalacia — years
DUE TO
(B) Generalized arteriosclerosis — years
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Tuberculosis, right lung — months

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 7 1967 to December 9 1967, that (I) (we) last saw the deceased alive on December 9, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C. Bravo M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/9/67
23C. PHYSICIAN'S NAME (Type): CESAR A. BRAVO M.D.
23D. ADDRESS: Bon Secours Hospital.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-15-67
24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): Brooklyn Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Elroy C. Wilson
ADDRESS: 1000 Brantly Ave

VS 150-REV. 1/1/65

D-200

BIRTH NO. 67 11964

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11964

1. NAME OF DECEASED (Type or Print): JOSEPH DIGGS

2. DATE AND HOUR OF DEATH: DEC. 6, 1967 | 9 30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY OF MD. HOSP.

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

17-01

D. STREET ADDRESS (If rural, give location): 735 WILMER COURT

5. SEX: M.

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): DIVORCED

8. DATE OF BIRTH: 3-17-08

9. AGE (In years last birthday): 59

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ELISE DIGGS

14. MOTHER'S MAIDEN NAME: MARX THOMAS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-030877

17. INFORMANT: HOSPITAL RECORD

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 157 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ADENOCARCINOMA OF STOMACH — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.-1 yr.

DUE TO

(B) WITH CARCINOMATOSIS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: AUG 1967

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca OF STOMACH

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 30, 1967 to December 6, 1967, that (I) (we) last saw the deceased alive on December 6, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Charles S. Harrison M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Dec. 6, 1967

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/13/67

24C. NAME of CEMETERY or CREMATORY: Balt. National Cemetery

24D. LOCATION (City, town, or county): Baltimore (State): Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Irvin P. Carroll

ADDRESS: 1712 W. Nolt Ave

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-532 67 11965

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X Registered No. 67 11965

1. NAME OF DECEASED (Type or Print): SANDKUHLER, BROTHER HENRY A

2. DATE AND HOUR OF DEATH: DECEMBER 3, 1967 | 10:00A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL, CATON & WILKENS AVES., BALTIMORE, MARYLAND 21229

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 21208 Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 33-00

D. STREET ADDRESS (If rural, give location): SACRED HEART MONASTERY

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): RELIGIOUS

8. DATE OF BIRTH: 11-25-94

9. AGE (In years last birthday): 73

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RELIGIOUS

10B. KIND OF BUSINESS OR INDUSTRY: RELIGIOUS

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOHN HENERY SANDKUHLER

14. MOTHER'S MAIDEN NAME: AUGUSTA FASTENRADH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.: 216 03 3576

17. INFORMANT: ST. AGNES HOSPITAL RECORDS

ADDRESS: CATON & WILKENS AVES., BALTO., MD. 21229

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HEART FAILURE

DUE TO

(B) ADVANCED A.S.C.V.D.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

422.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 28 1967 to DECEMBER 3 1967, that (X) (we) last saw the deceased alive on DECEMBER 3 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XX) (did not) view the body after death.

23A. SIGNATURE: Alejandro Mejia

M.O. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type): ALEJANDRO MEJIA

23D. ADDRESS: CATON & WILKENS AVES., BALTIMORE, MD. 21229

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Dec. 6, 1967

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967

25B. NAME OF REGISTRAR: Robert E. Fahey

25C. FUNERAL DIRECTOR: Hawes Funeral Home

ADDRESS: Reisterstown Md

D. E. H.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-532

BIRTH NO. 67 11966

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11966

1. NAME OF DECEASED (Type or Print): Rachel G. Wentz

2. DATE AND HOUR OF DEATH: 12-9-67 5:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 15 W. Madison

48

11-02

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: 5-27-89
9. AGE (In years last birthday): 78
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Fox
14. MOTHER'S MAIDEN NAME: Susan —

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 220-09-2955
17. INFORMANT: Dora E. Schroeder
ADDRESS: 3413 N. 12th Pl. Phoenix, Arizona

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 260X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Cerebrovascular Accident — 2 weeks

DUE TO

(B) Arteriosclerotic Cardiovascular Disease — ?

DUE TO

(C) Diabetes Mellitus — ?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-25 19 67 to 12-9 19 67, that (I) (we) last saw the deceased alive on 12-9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William L. Boddie M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-9-67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS: Maryland General Hospital

24A. BURIAL CREMATION REMOVAL (Specify): Burial
24B. DATE: Dec. 12, 1967
24C. NAME of CEMETERY or CREMATORY: St. Davids Church Cemetery
24D. LOCATION (City, town, or county) (State): West Manheim, Pa.

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Newell Funeral Home
ADDRESS: Towson 8-1169

D.F.

VS 150-REV. 1/1/65

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M-300

M.E. CASE NO. 67 11967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11967

1. NAME OF DECEASED (Type or Print): MEYD, Syrella Lynn

2. DATE AND HOUR OF DEATH: 12/8/67 7:00 A.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Maryland Hospital
38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 53-00
D. STREET ADDRESS (If rural, give location): Rosewood State Hospital

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Nev. Married
8. DATE OF BIRTH: 11/12/48
9. AGE (In years last birthday): 19
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 0
10B. KIND OF BUSINESS OR INDUSTRY: 0
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S. of A.

13. FATHER'S NAME: George C. Meyd.
14. MOTHER'S MAIDEN NAME: Orella Singer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): 0
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Chart
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 330.1

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Sepsis + peritonitis
DUE TO
(B) Perforated cecum +
DUE TO
(C) small bowel fistula
?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11/23
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Perforated cecum + colon resection
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No.

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 0
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/30 1967 to 12/8 1967, that (I) (we) last saw the deceased alive on 12/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Gerald D. Baker M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/8/67
23C. PHYSICIAN'S NAME (Type): Gerald D. Baker M.D.
23D. ADDRESS: U. of Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 11, 1967
24C. NAME of CEMETERY or CREMATORY: Harmony Ridge Cemetery
24D. LOCATION (City, town, or county) (State): Pikesville, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Revell Funeral Home Pikesville
ADDRESS: D.L.V.

VS 150-REV. 1/1/65

THE BODY OF JOHN HAMILTON HAS BEEN RELEASED ON APPROVAL BY DR SPITZ OF THE MEDICAL EXAMINER'S OFFICE OF BALTIMORE

IMPORTANT! FUNERAL DIRECTOR

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. H-543 67 11968

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11968

1. NAME OF DECEASED (Type or Print): JOHN HAMILTON

2. DATE AND HOUR OF DEATH: 12/10/67 4 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL 33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: DISTRICT OF COLUMBIA
C. CITY OR TOWN (If outside city limits, write RURAL and give township): WASHINGTON V-48
D. STREET ADDRESS (If rural, give location): 3212 WATER STREET

5. SEX: MALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 8-31-30
9. AGE (In years last birthday): 37
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Emma ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Ethel M. Hamilton
ADDRESS: 3212 Warder Street Washington, D. C. 20010

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARIAC ARREST
DUE TO
(B) LARGE CVA
DUE TO
(C) HASCVD

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

443X

CERTIFICATION APPROVED BY: CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/8 1967 to 12/10 1967, that (I) (we) last saw the deceased alive on 12/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harry K. Gernant M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/10/67
23C. PHYSICIAN'S NAME (Type): HARRY K. GERNANT M.D.
23D. ADDRESS: JOJNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Removal
24B. DATE: 12/14/67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State): Greenwood, South Carolina

25A. DATE REC'D BY HEALTH DEPT.: DEC 13 1967
25B. NAME OF REGISTRAR: Robert E. Falkenna
25C. FUNERAL DIRECTOR: Frazier's - Washington, D. C. 20001
ADDRESS

VS 150-REV. 1/1/65

SAB-50-33-77

B-240

BIRTH NO.

M.E. CASE NO.

67 11969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11969

1. NAME OF DECEASED (Type or Print): BECKLEY, PHILADELPHIA

2. DATE AND HOUR OF DEATH: 27 NOVEMBER 1967 10 20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 435 Watty Court 21201

X 11-04

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 10-30-80

9. AGE (In years last birthday): 87

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: Mrs. Betty Hall

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Records: BCH

ADDRESS: 4940 Eastern Avenue 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

1B. 153.8

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peritoneal Metastases of

DUE TO

(B) Probable Carcinoma of Colon

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CHF

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6 October '67 19 to 27 November 19 67. that (I) (we) last saw the deceased alive on 27 November 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Melvyn L. Tockman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 27 November 1967

23C. PHYSICIAN'S NAME (Type): Melvyn L. Tockman M.D.

23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify):

24B. DATE: 12-11-67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD

ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
U-525

67 11970 BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11970

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Unknown MALE

2. DATE AND HOUR PRONOUNCED DEAD: October 20, 1967 3:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 3000 blk. Hanover St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: UNKNOWN
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Unknown 00-00
D. STREET ADDRESS (If rural, give location): Unknown

5. SEX: Male
6. RACE: UNKNOWN
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)
8. DATE OF BIRTH
9. AGE (In years last birthday): Over 50
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT
ADDRESS

MEDICAL CERTIFICATION

1B. 795.5

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Undetermined

DUE TO far advanced decomposition

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner [X]

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 10/20/67

23A. BURIAL CREMATION, REMOVAL (Specify)
23B. DATE: 12-5-67
23C. NAME of CEMETERY or CREMATORY: ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL
23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967
24B. NAME OF REGISTRAR: Robert E. Farkyma
24C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD
ADDRESS

VS 151-REV. 1/1/65

G-612

BIRTH NO. 67 11971

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11971

1. NAME OF DECEASED (Type or Print): Mrs. Dora Estelle Greves

2. DATE AND HOUR OF DEATH: 12-10-67 2:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1914 Sulgrave Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 27-15

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1914 SULGRAVE AVE.

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 1882 1 October

9. AGE (In years last birthday): 85

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES T. CREW

14. MOTHER'S MAIDEN NAME: DORA I. DUER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO. 216-40-0623

17. INFORMANT: DOROTHY MASLIN

ADDRESS: 1914 SULGRAVE AVE. BALTO. MD.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 450.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Dec 8 1961 19 to Dec 19 67, that (I) (~~we~~) last saw the deceased alive on Dec 8 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: William G. Helfrich M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: December 11, 1967

23C. PHYSICIAN'S NAME (Type): William G. Helfrich M.D.

23D. ADDRESS: 5006 Roland Avenue, Balto., Md. 21210

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 12-13-67

24C. NAME of CEMETERY or CREMATORY: STILL POND CEMTY

24D. LOCATION (City, town, or county) (State): STILL POND, KENT, MD.

25A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

25B. NAME OF REGISTRAR: Robert E. Farkuna

25C. FUNERAL DIRECTOR: Victor N. Kennedy

ADDRESS: STILL POND, MD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-200

67 11972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11972

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HARVEY RUSS

2. DATE AND HOUR OF DEATH: 12-1 67 | 11:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 14-01

D. STREET ADDRESS (If rural, give location): Bolton Hill Nursing Home Balto 16

5. SEX: M

6. RACE: C

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 10-20-07

9. AGE (In years): 60 (last birthday)

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT:

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) HYPERKALEMIA

DUE TO

(B) INTERSTITIAL PULMONARY ~~PNEUMONITIS~~ FIBROSIS

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from 11-4 19 67 to 12-1 19 67, that (I) (we) last saw the deceased alive on 12-1 67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fridfjofur Bjornsson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-1 67

23C. PHYSICIAN'S NAME (Type): F. Bjornsson M.D.

23D. ADDRESS: Maryland General Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE: 12-7-67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State):

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

25B. NAME OF REGISTRAR: Robert E. Fashyna

25C. FUNERAL DIRECTOR:

ADDRESS:

MORTUARY SERVICE - BCHD

VS 150-REV. 1/1965

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
C-200

67 11973

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 11973

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLES CASEY

2. DATE AND HOUR PRONOUNCED DEAD: November 16, 1967 2:55 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-01

D. STREET ADDRESS (If rural, give location): 1114 Carson Court

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years last birthday): 51?

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MEDICAL CERTIFICATION

1B. 581.0

I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ruptured esophageal varix

DUE TO

(C) Hepatic fatty metamorphosis and cirrhosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D.

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED November 16, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

23B. DATE 12-5-67

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL

24A. DATE REC'D BY HEALTH DEPT. DEC 14 1967

24B. NAME OF REGISTRAR Robert E. Fahrney

24C. FUNERAL DIRECTOR

ADDRESS

MORTUARY SERVICE - BCHD

VS 151-REV. 1/1/65

T-610

67 11974 BALTIMORE CITY HEALTH DEPARTMENT 67 11974

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HENRY TRIPP

2. DATE AND HOUR PRONOUNCED DEAD: November 12, 1967 | 9:35 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1704 Montery Street D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1704 Montery St.

25-43

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White			71				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 4221

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: Novmeber 12, 1967

ANATOMY BOARD
UNIVERSITY MEDICAL SCHOOL

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
	12-5-67		

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 14 1967	Robert E. Farley M.D.	MORTUARY SERVICE - BCHD	

VS 151-REV. 1/1/65

B-1601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11975 Registered No. 67 11975

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BABER, Frederick Lee

2. DATE AND HOUR OF DEATH: 12-2-67 3:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Blvd., Baltimore, Maryland 21218

27

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Pikesville 53-00
D. STREET ADDRESS (If rural, give location): 35 Walker Ave.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Never Married
8. DATE OF BIRTH: 11-16-88
9. AGE (In years last birthday): 79
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dentist
10B. KIND OF BUSINESS OR INDUSTRY: Dental
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles M. Baber
14. MOTHER'S MAIDEN NAME: Jennie Miller

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): 1-2-18 to 12-14-18
16. SOCIAL SECURITY NO.: PN241-11-1688
17. INFORMANT: Records
ADDRESS: V.A. Hospital, Balto. Md. 21218

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

DUE TO

(B) A.S.H.D.

DUE TO

(C) B.P.H.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from October 8, 19 67 to December 2, 19 67, that ~~I~~ (we) last saw the deceased alive on December 2, 19 67 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: [signature]
M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12/2/67

23C. PHYSICIAN'S NAME (Type): Ismael Angulo M.D.
23D. ADDRESS: 3900 Loch Raven Blvd., Balto., Md. 21218

24A. BURIAL CREMATION, REMOVAL (Specify):
24B. DATE: 12-5-67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Newell Funeral Home
ADDRESS: Pikesville Md. 21208

D.E.N.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-656 1

BIRTH NO. 67 11976

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11976

1. NAME OF DECEASED (Type or Print): Turner, Catherine

2. DATE AND HOUR OF DEATH: 12/2/67 11:15 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 2-03

D. STREET ADDRESS (If rural, give location): 617 S. Durham

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 9-12-79

9. AGE (In years last birthday): 88

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Lewis Mundee

14. MOTHER'S MAIDEN NAME: Mary Langford

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. 600.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Papillary necrosis with

DUE TO acute ~~Poly~~ Pyelo nephritis

(B) Multiple ~~XXXX~~ Thrombo

DUE TO Emboli.

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ON 12-2-67 WHEN SHE ARRIVED D O A 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Henry R Black M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12/5/67

23C. PHYSICIAN'S NAME (Type): HENRY R. BLACK M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify):

24B. DATE: 12-7-67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State):

ANATOMY BOARD OF MARYLAND

UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

25B. NAME OF REGISTRAR: Robert E. Fahey M.D.

25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD

ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released as Non Med for the Medical Examiners Office by Dr. E. Wilson

D-62 D1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67-23883 67 11977 Registered No. X 67 11977

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BABY GIRL OURS

2. DATE AND HOUR OF DEATH: DECEMBER 4, 1967 8:07 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY OF MD. HOSP. 38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: BALTO CITY Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 4503 MAPLE AVE.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: 12/3/67
9. AGE (In years last birthday): If Under 1 Yr. Months / Days: 1 / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: TOM CLOUGH
14. MOTHER'S MAIDEN NAME: PEGGY OURS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: HOSPITAL CHART
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) IMMATURITY — INTERVAL BETWEEN ONSET AND DEATH: 1 DAY
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): (No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-3 19 67 to 12-4 19 67, that (I) (we) last saw the deceased alive on 12-4 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Theodore Wolf M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 12-4-67
23C. PHYSICIAN'S NAME (Type): THEODORE WOLFF M.D.
23D. ADDRESS: ANATOMY BOARD OF MD. HOSP.

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 12-8-67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State): UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL
ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-4321

BIRTH NO. Cambridge, Md 67 11978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11978

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Fields, Baby girl

2. DATE AND HOUR OF DEATH: November 29, 1967 | 2:05 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Maryland Hospital

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Dorchester Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Cambridge 59-00

D. STREET ADDRESS (If rural, give location): Box 13 Jacktown

5. SEX: Female

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: Nov 8, 1967

9. AGE (In years last birthday): If Under 1 Yr. Months: 0 Days: 21 | If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cambridge, Dorchester, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Everett Fields

14. MOTHER'S MAIDEN NAME: Betty J. ~~Fields~~ SPENCER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Shih-Wen Huang ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 751.21 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

	INTERVAL BETWEEN ONSET AND DEATH
(A) Lumbar meningomyelocele	22 days
DUE TO Non-communicating hydrocephalus	22 days
(B) Atelectasis	22 days
DUE TO Aspiration pneumonia, left	22 days
(C) Upper UBC secondary to atelectasis	22 days
Pseudomonas meningitis	6 days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Nov. 10 and Nov. 24, 67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Hydrocephalus Lumbar meningomyelocele

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-9 1967 to 11-30 1967, that (I) (we) last saw the deceased alive on 11-30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Shih-Wen Huang M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: Nov. 29, 1967

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: 505 W. 34th St. Baltimore, Md

24A. BURIAL CREMATION, REMOVAL (Specify):

24B. DATE: 12-8-67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State):

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

25B. NAME OF REGISTRAR: Robert E. Talley, M.D.

25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-500 1

67 11979 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11979

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CARUS L. AMY

2. DATE AND HOUR PRONOUNCED DEAD: November 20, 1967 | 11:02a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital D.O.A.

43 99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ?
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ?
D. STREET ADDRESS (If rural, give location): ?

00-00

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH:
9. AGE (In years last birthday): ? 40
If Under 1 Yr. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT:
ADDRESS:

MEDICAL CERTIFICATION

18. 903.5

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subdural Hemorrhage

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Howard and Camden Sts. 22-02

21D. TIME OF INJURY (APPROX.) (Month) 11 (Day) 20 (Year) 67 (Hour) ? m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Subject collapsed on sidewalk

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: November 20, 1967

23A. BURIAL CREMATION, REMOVAL (Specify):
23B. DATE: 12-12-61
23C. NAME of CEMETERY or CREMATORY: ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL
23D. LOCATION (City, town, or county) (State):

24A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD
ADDRESS:

VS 151-REV. 1/1/65

N85 4.2

1
W-426

67 11980 BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11980

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LAWRENCE WALKER

2. DATE AND HOUR PRONOUNCED DEAD: November 25, 1967 7:20 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED 12-14-67

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION GIVE STREET ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-01

D. STREET ADDRESS (If rural, give location): 48 Market Place

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White			51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Unknown ADDRESS:

MEDICAL CERTIFICATION

18. 581.0 I 340.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

Pneumonia and Pneumococcal Meningitis

(A) Bronchopneumonia due to fatty metamorphosis of liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Fatty metamorphosis of liver

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: November 26, 1967

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL

23A. BURIAL CREMATION, REMOVAL (Specify):

23B. DATE: 12-12-67

23C. NAME of CEMETERY or CREMATORY:

23D. LOCATION (City, town, or county) (State):

24A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

24B. NAME OF REGISTRAR: Robert E. Fahrney

24C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD

ADDRESS:

VS 151-REV. 1/1/65

Letter from M. E.'s office
12-14-67 M.H.

1
B-630

67 11981

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. Fayettesville, N.C.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11981

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): TINA BRITT

2. DATE AND HOUR PRONOUNCED DEAD: December 11, 1967 | 8:15 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Church Home and Hospital D.O.A.

35
99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3rd floor 1733 E. Baltimore St.

2-02

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Memale	White	Never Married	JUne 27 1967	5 Mo.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	———	Fayettesville N C	U S A

13. FATHER'S NAME: Bert Britt

14. MOTHER'S MAIDEN NAME: Bonnie Cummings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Bonnie Cummings
ADDRESS: 1733 E Baltimore Street

MEDICAL CERTIFICATION

1B. 5325 X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Interstitial pneumonia

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			YES

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 11, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county)	(State)
Burial	Dec 14 1967	Oxendine Cemetery	St Pauls	Robeson County NC

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 14 1967	Robert E. Farley, M.D.	The Dippel Brothers Inc	1800 E Lombard St

VS 151-REV. 1/1/65

B-523

67 11982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11982

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLOTTE BAUMEISTER

2. DATE AND HOUR OF DEATH: 5 Am 12-12-67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours Hospital Fayette & Pulaski Sts.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: Balto Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 2008 Royal Court Dr.

5. SEX: F

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 7-25-89

9. AGE (In years last birthday): 78 YRS.

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NO

17. INFORMANT: PATIENTS CHART

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 443X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure c̄ pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Hypertension, Atrial fibrillation — ?

DUE TO

(C) Arteriosclerotic Cardiovascular disease — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 10 19 67 to Dec 12 19 67, that (I) (we) last saw the deceased alive on Dec 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Yong Cho M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: Dec. 12, 67

23C. PHYSICIAN'S NAME (Type): YONG CHO M.D.

23D. ADDRESS: Bon Secours Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/14.67

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

25B. NAME OF REGISTRAR: Robert E. Tankersley

25C. FUNERAL DIRECTOR: J.T. Stansbury

ADDRESS: 6411 Windsor Mill

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
m-000

67 11983 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11983

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ARTHUR F. MAY

2. DATE AND HOUR PRONOUNCED DEAD: December 10, 1967 7:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 721 St. Paul St. (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: 11-01

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 721 St. Paul St. Apt. 11

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Divorced

8. DATE OF BIRTH: Oct.21, 1912

9. AGE (In years last birthday): 55

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Taxi Cab Driver

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Pleasant S. May

14. MOTHER'S MAIDEN NAME: Ayers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Myrtle Ruby

ADDRESS: 511 S. Vincent St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection [X] Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 12/10/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/13-1967

23C. NAME of CEMETERY or CREMATORY: St. Marys (Hampden)

23D. LOCATION (City, town, or county) (State): Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

24B. NAME OF REGISTRAR: Robert E. Fairbanks

24C. FUNERAL DIRECTOR: Frank A.

ADDRESS

VS 151-REV. 1/1/65

H-400

67 11984 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11984

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RUBIN HALE

2. DATE AND HOUR PRONOUNCED DEAD: December 10, 1967 | 7:30 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): University Hospital D.O.A.

38/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

18-01

D. STREET ADDRESS (If rural, give location): 17 N. Amity ~~St.~~ ST.

5. SEX: Male

6. RACE: Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Unknown

8. DATE OF BIRTH: July 5, 1909

9. AGE (In years last birthday): ~~60~~ 58

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): White Post, Clarke Co. Va. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Rubin Hale

14. MOTHER'S MAIDEN NAME: Lucy Lee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-10-0623

17. INFORMANT: Mrs Russell Howard

ADDRESS: Gettysburg, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

416 X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection [X] Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 11, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/14/67

23C. NAME of CEMETERY or CREMATORY: Lincoln Cemetery

23D. LOCATION (City, town, or county) (State): Gettysburg, Adams Co. Pa.

24A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

24B. NAME OF REGISTRAR: Robert E. Fahrney

24C. FUNERAL DIRECTOR: Robert J. Horalan

ADDRESS: Gettysburg, Pa.

VS 151-REV. 1/1/65

BIRTH NO. P-322 67 11985

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11985

1. NAME OF DECEASED (Type or Print): PATSCHKE, WILLIAM CHARLES

2. DATE AND HOUR OF DEATH: 12-11-67 | 11.05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 Franklin Square Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 8408-B Greenway Road

5. SEX: Male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 7-2-94

9. AGE (In years last birthday): 73

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Draftsman

10B. KIND OF BUSINESS OR INDUSTRY: Balto. City Govt.

11. BIRTHPLACE (State or foreign country): Baltimore MD

12. CITIZEN OF WHAT COUNTRY? U. S

13. FATHER'S NAME: CHARLES PATSCHKE

14. MOTHER'S MAIDEN NAME: Annie Schomberg ~~CHARLES PATSCHKE~~

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES

(If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 220-09-0820

17. INFORMANT: Celeste Patschke, 8408 Greenway Rd. Dr. S. Lee 21234 F. S. H

ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rupture, abdominal aneurysm recent

DUE TO

(B)

DUE TO

(C) acute & old MI, 2° occlusion coronary art. I

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-6 19 67 to 12-11 19 67, that (I) (we) last saw the deceased alive on 12-11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sang Bichd Lee M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-11-67

23C. PHYSICIAN'S NAME (Type): Dr. S. Lee M.D.

23D. ADDRESS: Franklin Square Hosp. Balto. Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-15-67

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

25B. NAME OF REGISTRAR: Robert L. Fairbrya

25C. FUNERAL DIRECTOR: Wm. E. Johnson. ADDRESS: 8521 Loch Raven Blvd. 21204

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

K-320

67 11986 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11986

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): THEODORE T. KATUSZ

2. DATE AND HOUR PRONOUNCED DEAD: December 12, 1967 8:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - Dundalk 53-00

D. STREET ADDRESS (If rural, give location): 2802 Plainfield Road

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Oct. 20, 1920

9. AGE (In years last birthday): 47

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steam Dept.

10B. KIND OF BUSINESS OR INDUSTRY: Bethlehem Steel Co.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Stanley Katusz

14. MOTHER'S MAIDEN NAME: Frances Olszewski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes

(If yes, give war or dates of service): Navy WWII

16. SOCIAL SECURITY NO.: 203-05-5260

17. INFORMANT: (Wife) ADDRESS: Dundalk, Md. 21222

Mrs. Doris E. Katusz, 2802 Plainfield Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I. 1B. E 812.4

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cranio-Cerebral Injury

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Plainfield Road - 54 ft. South of Oakwood Road

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12/9/67 7:01 P. m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Pedestrian struck by car 53-00

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 12/12/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/15/67

23C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cem.

23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

24B. NAME OF REGISTRAR: Robert E. Farkyma

24C. FUNERAL DIRECTOR: John J. Duda, 7922 Wise Ave. Dundalk, Md.

ADDRESS

VS 151-REV. 1/1/65

N 856.2

L-20 d

67 11987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1995 67 11987

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lacey ~~Lacy~~, Willis

2. DATE AND HOUR OF DEATH: 12-12-67 | 630 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 BOLTON, NURSING CENTER

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD

B. COUNTY: X

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 18-01

D. STREET ADDRESS (If rural, give location): 202 N. Fremont Ave.

5. SEX: MALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 12/28/97

9. AGE (In years last birthday): 69

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer-Ret.

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Richmond Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Willis J. Lacey

14. MOTHER'S MAIDEN NAME: Maybell ?

15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-07-9770

17. INFORMANT: BOLTON HILL

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

443 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: CVA, left — 1 mo.

(B) DUE TO: Hypertensive CV disease — years

(C): arteriosclerosis gen. — years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/7 1967 to 12/12 1967, that (I) (we) last saw the deceased alive on 12/12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: al Macht M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/12/67

23C. PHYSICIAN'S NAME (Type): ALLAN H. MACHT M.D.

23D. ADDRESS: 2 E. READ ST. Balt Md 21202

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/15/67

24C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Park

24D. LOCATION (City, town, or county) (State): Arbutus Md.

25A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

25B. NAME OF REGISTRAR: Robert E. Falkenna

25C. FUNERAL DIRECTOR: Williams Funeral Home

ADDRESS: 3199 N. Schroeder St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
D-500

67 11988 BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11988

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES B. DONOHUE

2. DATE AND HOUR PRONOUNCED DEAD: December 12, 1967 | 9:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): ST AGNES HOSPITAL (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 942 E. 41st St.

9-01

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	August 2, 1914	53				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tool Engineer	Westinghouse Corp.	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: James B. Donohue

14. MOTHER'S MAIDEN NAME: Elizabeth McShane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-01-0394

17. INFORMANT: Mrs. Elizabeth F. Donohue ADDRESS: 942 E. 41st St

MEDICAL CERTIFICATION

1B. 4221

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — (A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 12/12/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	12/15/1967	Loudon Park Cemetery	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 14 1967	Robert E. Farkey	John A. Moran Inc.	3000 E. Baltimore St.

VS 151-REV. 1/1/65

M-235

Med Exam - Released on approval

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11989 Registered No. 67 11989

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MC DONALD, NELLIE G.

2. DATE AND HOUR OF DEATH: 12-12-67 | 1:55 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2904 Westfield Ave.

36

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	white	widowed	10-07-74	93		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES D. ROBB
14. MOTHER'S MAIDEN NAME: ELIZABETH HARGEST

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Chart Record
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral infarction — 13 hours
DUE TO
(B) Generalized arteriosclerosis — years
DUE TO
(C) Pneumonitis — 2 days

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY: J. Albert Lee M.D. CHIEF OR ASST. MEDICAL EXAMINER 12-14-67

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2904 Westfield Ave.
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12-11-67
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☑
21F. HOW DID INJURY OCCUR? While walking, she collapsed and hit head against the floor.

22. I certify that (I) (this hospital) attended the deceased from 12-11 1967 to 12-12 1967, that (I) (we) last saw the deceased alive on 12-12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. Lee M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12-12-67
23C. PHYSICIAN'S NAME (Type): J. Lee M.D.
23D. ADDRESS: FRANKLIN SQUARE HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/15/67
24C. NAME OF CEMETERY or CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: M. Eisemann
ADDRESS: 6067 Hayd Rd

VS 150-REV. 1/1/65

C-345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11990 Registered No. 67 11990

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CATLIN ALBERTA

2. DATE AND HOUR OF DEATH: 12-6-67 | 6:30 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3705 MANCHESTER AVE #15

2718

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	Divorced	7/29/06	61				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Wm Henry Krig

14. MOTHER'S MAIDEN NAME: Mary E. Hughes

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Myrtle Elliott

ADDRESS: 3705 Manchester Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2-3 days

DUE TO

(B) Coronary artery disease — 10-12 yrs

DUE TO

(C) ASCVD : Diabetes M. — 12-15 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from 11-5 1967 to 12-6 1967, that (I) (we) last saw the deceased alive on 12-6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 12-6-67

23C. PHYSICIAN'S NAME (Type): Edito C. Galvez M.D.

23D. ADDRESS:

24A. BURIAL CREMATION REMOVAL (Specify): Burial

24B. DATE: 12/9/67

24C. NAME of CEMETERY or CREMATORY: Oak Lawn

24D. LOCATION (City, town, or county) (State): Balto Co.

25A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

25B. NAME OF REGISTRAR: [signature]

25C. FUNERAL DIRECTOR: P. A. Heemann

ADDRESS: 6067 Hay Rd

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B.6501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 11991 Registered No. 67 11991

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BROWN ERNEST

2. DATE AND HOUR OF DEATH: 12/8/67 6:15 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: 25-33
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2613 KENT STREET

5. SEX: M 6. RACE: C 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH: 2/26/15 9. AGE (In years last birthday): 52 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unk

14. MOTHER'S MAIDEN NAME: unk

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-05-7176

17. INFORMANT: Records ADDRESS

MEDICAL CERTIFICATION

18. 157X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pancreatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 1 M

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/26 1967 to 12/8 1967, that (I) (we) last saw the deceased alive on 12/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kurt P Sligar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/8

23C. ~~PHYSICIAN'S NAME (Type)~~ M.D.

23D. ADDRESS: University Hosp

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/15/67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn

24D. LOCATION (City, town, or county) (State): Baltimore, Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Charles A Rice & Son

ADDRESS: Barre St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

H. 620

67 11992

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 11992

BIRTH NO.

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GEORGE O. HARRIS

2. DATE AND HOUR PRONOUNCED DEAD: December 12, 1967 12:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 908 Burgundy St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-01

D. STREET ADDRESS (If rural, give location): 908 Burgundy St.

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 2/18/06

9. AGE (In years lost birthday): 61 62

If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charley Harris

14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-09-7970

17. INFORMANT: Rosetta Johnson

ADDRESS: 4022 Greenspring

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 157X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Pancreas

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, ~~M.D.~~ M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 12/12/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/16/67

23C. NAME of CEMETERY or CREMATORY: Mt. Calvery

23D. LOCATION (City, town, or county) (State): Brooklyn, Maryland

24A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

24B. NAME OF REGISTRAR: Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR: Charles A. Rice

ADDRESS: 661 W. Barre St.

VS 151-REV. 1/1/65

K-61

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 11993

M.E. CASE NO. John

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11993

1. NAME OF DECEASED (Type or Print): Mr. Phillip Kraft

2. DATE AND HOUR OF DEATH: Dec 12, 1967 1:05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home + Hosp. Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, Md 53.00
D. STREET ADDRESS (If rural, give location): 5923 Shady Spring Ave

35

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	D	3/2/1919	48		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert J. Kraft

14. MOTHER'S MAIDEN NAME: Florence Bellin (Austin)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 215-01-7631

17. INFORMANT: Robert Kraft

ADDRESS: 6001 Shady Spring Ave (87)

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 002.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fibrocaseous cavitary tuberculosis, both upper lobes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/11 1967 to 12/12 1967, that (I) (we) last saw the deceased alive on 12/12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Francisco Baltazar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12/12/67

23C. PHYSICIAN'S NAME (Type): FRANCISCO BALTAZAR, M.D.

23D. ADDRESS: Church Home + Hosp Baltimore 31, Md.

24A. BURIAL CREMATION REMOVAL (Specify): Burial

24B. DATE: Dec 14/67

24C. NAME of CEMETERY or CREMATORY: Balto Cem

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

25B. NAME OF REGISTRAR: Robert E. Falkner

25C. FUNERAL DIRECTOR: Philip Henri Jans

ADDRESS: 2024 Orleans St.

VS 150-REV. 1/1/65

50-71-09 GG 1

P-623

BIRTH NO. 67 11994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11994

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (GEORGE E. PRECHTEL) GEORGE PRECHTEL

2. DATE AND HOUR OF DEATH 12/9/67 5:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE 21224, MARYLAND

B/B. 15-02

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE

D. STREET ADDRESS (If rural, give location) 1732 N. PAYSON STREET #21217

5. SEX MALE

6. RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE

8. DATE OF BIRTH OCT. 18 1877

9. AGE (In years lost birthday) ~90

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper

10B. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John F. Prechtel

14. MOTHER'S MAIDEN NAME Helena Wittekindt

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 219 32 2088 A.

17. INFORMANT Miss Catherine Prechtel ADDRESS MD.
RECORDS: BCH 4940 EASTERN AVE. BALTO. 21224,

MEDICAL CERTIFICATION

18. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) UNKNOWN - SUDDEN

DUE TO

(B) Arteriosclerosis, CBS, ASCVD

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/6/67 19 to 12/9 19 67, that (I) (we) last saw the deceased alive on 12/9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Paul Michelson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED 12/9/67

23C. PHYSICIAN'S NAME (Type) DR. PAUL MICHELSON
PAUL MICHELSON M.D.

23D. ADDRESS BALTIMORE 21224, MARYLAND
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 12/12/67

24C. NAME of CEMETERY or CREMATORY Greenmount Cemetery

24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. DEC 14 1967

25B. NAME OF REGISTRAR Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC. ADDRESS BALTIMORE, MARYLAND

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. R-200 67 11995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 48 67 11995

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Capitola Reese (CAPITOLA NOVELLA REESE)

2. DATE AND HOUR OF DEATH 12-12-67 12:40 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

90 Bolton Hill Nursing and Convalescent Center

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21218 12-01

D. STREET ADDRESS (If rural, give location) 409 Bretton Pl.

5. SEX Female

6. RACE White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single

8. DATE OF BIRTH Apr. 4. 1881

9. AGE (In years last birthday) 86

If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas Henry Reese

14. MOTHER'S MAIDEN NAME Novella Haney

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-54-9479

17. INFORMANT Mrs. Novella H. Lucas ADDRESS 409 Bretton Place, Baltimore 21218

MEDICAL CERTIFICATION

18. 430.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pneumonia, bronchial — weeks

DUE TO

(B) Generalized arteriosclerosis — years

DUE TO

(C) Chronic heart failure — years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/22 1965 to 12/12 1967, that (I) (we) last saw the deceased alive on 12/12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Al Macht M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED 12/13/67

23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT M.D.

23D. ADDRESS 2 E. READ ST 21202

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE Dec. 14. 1967

24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State) Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT. DEC 14 1967

25B. NAME OF REGISTRAR Robert E. Tankey M.D.

25C. FUNERAL DIRECTOR HENRY SANDER & SONS. INC. ADDRESS Baltimore Md.

VS 150-REV. 1/1/65

1

J-520

67 11996 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11996

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): VIOLA JAMES

2. DATE AND HOUR PRONOUNCED DEAD: December 8, 1967 | 1:45 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 662 West Mulberry St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-01

D. STREET ADDRESS (If rural, give location): 662 West Mulberry St.

5. SEX: Female

6. RACE: Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Separated

8. DATE OF BIRTH: 4/14/94

9. AGE (In years last birthday): 72 73

If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress

10B. KIND OF BUSINESS OR INDUSTRY: Factory

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Robert Gaines

14. MOTHER'S MAIDEN NAME: Harriet

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-12-3403

17. INFORMANT: Mrs Rosa James, same

ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 422.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO:

(C):

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 8, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 12/13/67

23C. NAME of CEMETERY or CREMATORY: Mt Auburn Cemetry

23D. LOCATION (City, town, or county) (State): Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967

24B. NAME OF REGISTRAR: Robert E. Farley

24C. FUNERAL DIRECTOR: A Halstead

ADDRESS: 1206 W North AVe

VS 151-REV. 1/1/65

1 2 0 2 0 1 2 0 1 8

1
P-400

67 11997 BALTIMORE CITY HEALTH DEPARTMENT 67 11997

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES H. PAUL

2. DATE AND HOUR PRONOUNCED DEAD: December 10, 1967 M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1848 Division St. (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-03
D. STREET ADDRESS (If rural, give location): 1848 Division St.

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 1891
9. AGE (In years, last birthday): 78 76
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): M od arrier
10B. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Fr ank Paul
14. MOTHER'S MAIDEN NAME: Hattie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) ? (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Guierthiner Keels
ADDRESS: 3711 Chesolm Rd

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection [X] Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 12/10/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 12/15/67
23C. NAME of CEMETERY or CREMATORY: Arbutus Mem Park
23D. LOCATION (City, town, or county) (State): Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: Adolphus Halstead
ADDRESS: 1206 W North Ave

VS 151-REV. 1/1/65

S-424

67 11998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 11998

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lula M. Slagel - Schlegel

2. DATE AND HOUR OF DEATH: 12/14/67 5:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 49 North Charles General

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 21230
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 23-02
D. STREET ADDRESS (If rural, give location): 1604 S. Charles St.

5. SEX: Female
6. RACE: white
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: 10-5-85
9. AGE (In years last birthday): 82
If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jesse Redmond ~~Redmond Jesse~~
14. MOTHER'S MAIDEN NAME: Louisa Clark

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service): C216-05-6110 Dp
16. SOCIAL SECURITY NO.: 214-50-2138
17. INFORMANT: Chart N.C.G.H.
ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 331 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular accident
DUE TO
(B) Generalized Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-13 1967 to 12-14 1967, that (I) (we) last saw the deceased alive on 12-14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: F. Q. Aguirre, Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12-14-67
23C. PHYSICIAN'S NAME (Type): Dr. Walter Kohn M.D.
23D. ADDRESS: 102 E. Fort Ave Balto 21230

24A. BURIAL CREMATION, REMOVAL (Specify): Burial -
24B. DATE: Sat. Dec 16, 1967
24C. NAME of CEMETERY or CREMATORY: Western Cem.
24D. LOCATION (City, town, or county) (State): Balto Md - 21223

25A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967
25B. NAME OF REGISTRAR: Robert E. Farber
25C. FUNERAL DIRECTOR: CURTIS E. EVANS
ADDRESS: 1400 N. Charles 21230

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

W-420 67 11999 BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 11999

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPHINE L. WILLIS

2. DATE AND HOUR PRONOUNCED DEAD: December 11, 1967 | 8:30 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 242 N. Rose St. D.O.A.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-02
D. STREET ADDRESS (If rural, give location): 242 N. Rose St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Married	1/18/05	62				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Trained Nurse		New York State	U.S.A.

13. FATHER'S NAME: J. Rose

14. MOTHER'S MAIDEN NAME: unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 452-44-2635

17. INFORMANT: S. Ivan Willis ADDRESS: 242 N Rose St. Baltimore Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ASCVD

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

DATE SIGNED: December 11, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	Dec 13/67	Chester Cemetery	Chesterlown Kent Co. Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
DEC 14 1967	Robert E. Farley M.D.	Warren V. Williams	306 Welsh ave Chestertown Md.

VS 151-REV. 1/1/65

42-42-11 1B

W-250

BIRTH NO. 67 12000

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 12000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ANNIE M. WICKHAM

2. DATE AND HOUR OF DEATH: 12-9-67 8:54 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
26-08
D. STREET ADDRESS (If rural, give location): 304 S. CONKLING ST. #21224

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 3-13-97
9. AGE (In years last birthday): 70
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES AUSTIN
14. MOTHER'S MAIDEN NAME: SALLIE MC CULLOH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-54-0671-T
17. INFORMANT: RECORDS-BCH-4940 EASTERN AVENUE-BALTIMORE, MD
ADDRESS: 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction
DUE TO
(B) Arteriosclerotic Heart Disease — 20 years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 21 19 64 to Nov. 19 67, that (I) (we) last saw the deceased alive on Nov 13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sidney D. Kreider M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 12/9/67
23C. PHYSICIAN'S NAME (Type): DR. SIDNEY D. KREIDER M.D.
23D. ADDRESS: BCH-4940 EASTERN AVENUE, BALTIMORE, MD. 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/12/67
24C. NAME of CEMETERY or CREMATORY: Balto. Cemetery
24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: DEC 14 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Joseph M. Zimmerman
ADDRESS: 263 S. Conkling St.

VS 150-REV. 1/1/65